BOOK OF BENEFITS

SUMMARY PLAN DESCRIPTION

UNCLASSIFIED
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About Your Benefits

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Introduction

About This Summary Plan Description

PanTeXas Deterrence, LLC ("PXD" or "Company") offers Eligible Employees and their Spouses and Dependents valuable benefits through the PXD Benefits Program (the "Benefits Program" or the "Program").

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

The PXD Benefits Program and certain benefit plans, as described in this Summary Plan Description (SPD), commonly referred to as the Book of Benefits, are intended to conform to all applicable legal requirements including, but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code of 1986 (the "Code"), and all regulations issued thereunder. It is further intended that the Program meet the requirements of a Cafeteria Plan under Code Section 125 and Treasury Regulations thereunder. If the employee elects qualified benefits under the Program, those benefits may be eligible for exclusion from the employee's income under Code Section 125(a). (This means you have the opportunity to pay for certain benefits on a pre-tax basis.)

A copy of this SPD is also available to you at **https://pantex.energy.gov/employees-retirees/benefits**

This SPD replaces any prior SPD or Summary of Material Modification. Payment of benefits is subject to all terms and conditions of the Program as described in this SPD.

Other insurance coverage may be available to employees on a voluntary basis. Contact the Pantex Benefits Office to obtain additional information.

Note: Neither receipt of this SPD nor use of the term "you" means that you are an Eligible Employee or Eligible Dependent under the Program. You are eligible only if you satisfy the applicable eligibility requirements. See the Eligibility section. In addition, the Company reserves the right to amend, modify, suspend, or terminate the PXD Benefits Program, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law. The Company further reserves the right to change the amount of required participant contributions for coverage at any time, with or without advance notice to participants.

About Your Benefits

Through the PXD Benefits Program, you can choose among different levels and types of coverage.

You may want or need coverage in some benefit areas, but not in others. Or you may want a higher level of coverage under one benefit plan than under others. Your personal situation can also change from year to year. As a result, the Program's approach lets you do the following:

- Put together a combination of benefits that meets your needs
    - Change certain benefits each fall during the Open Enrollment period effective for the next plan year
    - Have a valuable tax advantage when you pay for certain coverage on a pre-tax basis

Note: Some terms are defined as they are addressed and/or within the Glossary of this SPD. Be sure to review the defined terms as they include important information. The Administrative Information section of this SPD also has important information regarding your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

Every attempt has been made to ensure the accuracy of this summary. However, its contents are not legally binding nor should it be considered as a substitute to the actual contract language or Company policies.

Not an Employment Contract

The receipt of this SPD document does not create a right for you to be retained in employment nor prevent the Company from terminating your employment for any reason. Nothing in this document shall be construed as an employment contract or employment agreement.

Your Benefits

- Provide eligibility for you and your family
- Offer coverage automatically
- Allow you to choose the coverage that is right for you
- Offer tax-effective coverage

Eligibility

Employee

You are eligible to participate in the benefit plans described in this book if you are employed and paid as a Full-Time Employee of the Company working on a regular basis, or a Full-Time Temporary Employee who is hired to work at least 12 months. Part-Time Employees and Full-Time Temporary Employees who are hired to work less than 12 months are also eligible for many of the benefits described in this book. Ad Hoc Employees are not eligible to participate in any benefit plans. Individuals who are paid as independent contractors or who are leased from another employer are not Employees and are not eligible to participate in the benefits plans described in this SPD.

When referring to bargaining unit employees, unless directly specified, this SPD is referencing the following:

- Metal Trades Council (MTC)
- Pantex Guards Union (PGU)

When referring to non-bargaining unit employees, this SPD is referencing all exempt salaried employees and non-exempt salaried employees.

If you are a bargaining unit employee, you are eligible for business travel accident insurance and those benefit plans in which your bargaining unit has agreed to participate.

The terms "Full-Time Employee," "Part-Time Employee," "Full-Time Temporary Employee," and "Ad Hoc Employee" are defined in the Glossary.

Dependents

You may choose to cover your Eligible Dependents for medical (including prescription drug), dental, vision, Life Insurance, and Special Accident Insurance coverage. Your Eligible Dependents may also use the Employee Assistance Program.

You are obligated to submit proof of dependent status for your Spouse and Children. Documentation includes a birth certificate, Social Security card, marriage certificate, and/or other documents required to prove eligibility.

Medical (including prescription drugs), dental, and vision coverage may be continued for an unmarried Child who is permanently and totally disabled and incapable of self-support due to a physical or mental handicap that began before he or she reached the age at which coverage would otherwise be terminated. You must submit proof of the Child's disability to the Claims Administrator within 31 days after attaining the maximum age. Additional proof of the Child's continuing disability will be required periodically.

Special Accident Insurance coverage (PGU bargaining unit employees only) may be continued indefinitely for an unmarried Child who is incapable of self-support due to a physical or mental handicap that began before he or she reached age 19.

When your dependents are no longer eligible for health care coverage, they may be eligible to continue coverage for up to 36 months under COBRA. See the "Administrative Information" section for information on COBRA.

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

Special Eligibility Rules for Families

If you and your Spouse work for the Company and are eligible to participate in the Company's benefit plans, you may enroll in the Plan as an Employee, or you may be enrolled as a Spouse. However, you may not enroll for coverage as an Employee and as a Spouse. In addition, only one of you may enroll your Eligible Dependent Child(ren).

New Hires and When Coverage Begins

- Full-Time Employees and Full-Time Temporary Employees hired to work at least 12 months are eligible for coverage for most benefit plans, including health care, life, accident insurance and the 401(k) Savings Plan on their first day of work.
- Part-Time Employees and Full-Time Temporary Employees hired to work less than 12 months are immediately eligible for Life and Accident Insurance and the 401(k) Savings Plan, and become eligible for medical, dental, and vision coverage after 90 days of service.
- Ad Hoc Employees, as defined in the Glossary, are not eligible to participate in any benefit plans.

Full-Time Employees and Full-Time Temporary Employees Hired to Work At Least 12 Months

Benefit Plan	Eligible	Coverage Begins	Who Pays?
Medical (including Prescription Drugs)	All employees: first day at work.	All employees: first day at work provided you enroll within 31 days.	You and the Company share the cost.
Dental	All employees: first day at work.	All employees: first day at work provided you enroll within 31 days.	You and the Company share the cost.
Vision	All employees: first day at work.	All employees: first day at work provided you enroll within 31 days.	You and the Company share the cost.
Employee Assistance Program	All employees: first day at work.	All employees: first day at work. No enrollment required.	Company pays.
Flexible Spending Accounts	All employees: first day at work.	All employees: first day at work provided you enroll within 31 days.	You pay.
Short-Term Disability	Non-bargaining employees: after one month of service. Bargaining unit employees: refer to your collective bargaining agreement.	Non-bargaining employees: after one month of service. Bargaining unit employees: refer to your collective bargaining agreement.	Company pays.
Basic Long-Term Disability	All employees: first day at work.	All employees: first day at work. You must exhaust Short-Term Disability benefits first.	Company pays.
Long-Term Disability Buy-Up	All employees except PGU: first day at work.	All employees except PGU: first day at work. You must exhaust Short-Term Disability benefits first.	You pay.
Basic Life Insurance (1 times salary or $50,000)	All employees: first day at work.	All employees: first day at work.	Company pays.
Basic Accidental Death & Dismemberment (AD&D) Insurance (1 times salary or $50,000)	All employees: first day at work.	All employees: first day at work.	Company pays.
Voluntary AD&D Insurance	All non-bargaining employees: first day at work.	All non-bargaining employees: first day at work.	You pay.
Special Accident Insurance	PGU bargaining unit employees: first day at work	PGU bargaining unit employees: first day at work.	You pay.
Group Universal Life (GUL) Insurance (Includes	All employees: first day at work.	All employees: first day at work.	You pay.

Benefit Plan	Eligible	Coverage Begins	Who Pays?
Spouse and Child Life)			
Business Travel Accident Insurance	All employees: first day at work.	All employees: first day at work.	Company pays.
401(k) Savings Plan	All employees: first day at work.	All employees: first day at work.	You pay. Company matches a portion.
Enhanced Defined Contribution Savings Plan	All employees not eligible for the Pension Plan: first day at work.	All employees not eligible for the Pension Plan: first day at work.	Company pays.
Pension Plan (Closed to new participants)	All eligible employees as defined in the Pension Plan: after completing one year of service.	All eligible employees as defined in the Pension Plan: after completing one year of service.	You and the Company share the cost. Exception: MTC and PGU employees do not share in the cost.
Severance Plan	All employees: first day at work. Exception: Temporary employees are not eligible.	All employees: first day at work. Exception: Temporary employees are not eligible.	Company pays.

Part-Time Employees and Full-Time Temporary Employees Hired to Work Less Than 12 Months

Benefit Plan	Eligible	Coverage Begins	Who Pays?
Medical (including Prescription Drugs)	All employees: after 90 days of service.	All employees: after 90 days of service provided you enroll within 31 days.	You and the Company share the cost.
Dental	All employees: after 90 days of service.	All employees: after 90 days of service provided you enroll within 31 days.	You and the Company share the cost.
Vision	All employees: after 90 days of service.	All employees: after 90 days of service provided you enroll within 31 days.	You and the Company share the cost.
Employee Assistance Program	All employees: first day at work.	All employees: first day at work. No enrollment required.	Company pays.
Flexible Spending Accounts	All employees: after 90 days of service.	All employees: after 90 days of service provided you enroll within 31 days.	You pay.
Short-Term Disability	Non-bargaining employees: after one month of service. Bargaining unit employees: refer to your collective bargaining agreement.	Non-bargaining employees: after one month of service. Bargaining unit employees: refer to your collective bargaining agreement.	Company pays.
Basic Long-Term Disability	All employees: first day at work.	All employees: first day at work. You must exhaust Short-Term Disability benefits first.	Company pays.
Long-Term Disability Buy-Up	All employees except PGU: first day at work.	All employees except PGU: first day at work. You must exhaust Short-Term Disability benefits first.	You pay.
Basic Life Insurance (1 times salary or $50,000)	All employees: first day at work.	All employees: first day at work.	Company pays.
Basic Accidental Death & Dismemberment (AD&D) Insurance (1 times salary or $50,000)	All employees: first day at work.	All employees: first day at work.	Company pays.
Voluntary AD&D Insurance	All non-bargaining employees: first day at work.	All non-bargaining employees: first day at work.	You pay.
Special Accident Insurance	PGU bargaining unit employees: first day at work	PGU bargaining unit employees: first day at work.	You pay.
Group Universal Life (GUL) Insurance (Includes	All employees: first day at work.	All employees: first day at work.	You pay.

Benefit Plan	Eligible	Coverage Begins	Who Pays?
Spouse and Child Life)			
Business Travel Accident Insurance	All employees: first day at work.	All employees: first day at work.	Company pays.
401(k) Savings Plan	All employees: first day at work.	All employees: first day at work.	You pay. Company matches a portion.
Enhanced Defined Contribution Savings Plan	All employees not eligible for the Pension Plan: first day at work.	All employees not eligible for the Pension Plan: first day at work.	Company pays.
Pension Plan (Closed to new participants)	All eligible employees as defined in the Pension Plan: after completing one year of service.	All eligible employees as defined in the Pension Plan: after completing one year of service.	You and the Company share the cost. Exception: MTC and PGU employees do not share in the cost.
Severance Plan	All employees: first day at work. Exception: Temporary employees are not eligible.	All employees: first day at work. Exception: Temporary employees are not eligible.	Company pays.

Enrollment

Some benefits are provided automatically, and others require enrollment.

Benefits with no enrollment required:

- Employee Assistance Program
- Short-Term Disability
- Basic Long-Term Disability
- Business Travel Accident Insurance
- Pension Plan (Closed to new participants)
- Enhanced Defined Contribution, component to the 401(k) Savings Plan
- Basic Life Insurance (non-bargaining, MTC, and PGU bargaining unit employees only)
- Basic Accidental Death and Dismemberment (non-bargaining, MTC, and PGU bargaining unit employees only)

You may elect the following benefits when you are first eligible:

- Medical (including Prescription Drugs)
- Dental
- Vision
- Flexible Spending Accounts (Health Care and Dependent Care)
- Group Universal Life (GUL) Insurance (including Spouse and Child Life Insurance)
- Voluntary Accidental Death and Dismemberment (non-bargaining employees only)
- Special Accident Insurance (PGU bargaining unit employees only)
- 401(k) Savings Plan
- Long-Term Disability Buy-Up (excludes PGU bargaining unit employees)

To Enroll:

To participate in these benefits, you must enroll with the Company. For the 401(k) Savings Plan and GUL plans, you must enroll through the applicable vendor websites.

- Enroll yourself and Eligible Dependents (if applicable)
- Authorize the Company to deduct from your Pay your share of the coverage you elect

Enrollment information is available from the Pantex Benefits Office or website. When you begin work for the Company, the GUL vendor and 401(k) Savings Plan Recordkeeper will be notified of your employment and you will then be able to log on to their websites to enroll.

Note: As a participant in the Life Insurance, Accident Insurance, or the 401(k) Savings Plan, you must name a Beneficiary to receive any benefits that may become payable in the event of your death.

When You May Elect Coverage

You may elect benefits coverage when you first become eligible. You also may enroll for some benefit plans during the annual Open Enrollment period. The annual Open Enrollment is held typically during October or November for coverage effective the following January 1.

When Coverage Begins

New Hires

If you enroll as a newly hired employee, your coverage will begin according to the following chart, provided you meet the Plan's eligibility requirements. Any coverage you elect for your Eligible Dependents will begin on the same day your coverage begins.

Benefit Plan	Your Coverage Will Begin…
Medical (including Prescription Drugs), Dental, and Vision	Full-Time Employees and Full-Time Temporary Employees hired to work at least 12 months: on your first day of work, provided you enroll within 31 days of that date. If you do not enroll within 31 days after you first become eligible, you will have to wait until Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1. Election and enrollment changes made as a result of a Qualifying Life Event must be made within 31 days of the event. In this case, coverage is effective on the Qualifying Life Event date. Part-Time Employees and Full-Time Temporary Employees hired to work less than 12 months: on the first day of work following 90 days of service, provided you enroll within 31 days of that date. If you do not enroll within 31 days after you first become eligible, you will have to wait until Open Enrollment to enroll. Your coverage will become effective the first day of the plan year following Open Enrollment, currently January 1. Election and enrollment changes made as a result of a Qualifying Life Event must be made within 31 days of the event. In this case, coverage is effective on the qualifying event date. See the note related to newborns in the section below.
Employee Assistance Program (EAP)	On your first day of work.
Flexible Spending Accounts	Payroll deductions begin as soon as administratively possible and in accordance with IRS rules following your election; however, you may claim eligible expenses incurred on or after your date of hire or on the date of the Qualifying Life Event. Full-Time Temporary Employees are eligible after 90 days of service. Before and after-tax deductions are made based on IRS rules. Part-Time Employees are not eligible.
Short-Term Disability	Refer to the "Disability Coverage" section.
Long-Term Disability	On your first day of work if you are a Full-Time Employee or Temporary Employee hired to work at least 12 months or after 90 days of service if you are a Full-Time Temporary Employee and were hired to work less than 12 months or a Part-Time Employee who has completed 90 days of service.
Basic Life Insurance	All employees are automatically covered for Basic Life Insurance coverage. No enrollment action is necessary.
Basic Accidental Death & Dismemberment (AD&D) Life Insurance	All employees are automatically covered for Basic AD&D coverage. Enrollment is required for additional Voluntary AD&D coverage.
Voluntary AD&D Insurance	All non-bargaining employees coverage begins on the day you enroll, provided you enroll within 31 days after you become eligible.

Benefit Plan	Your Coverage Will Begin…
Group Universal Life Insurance	On the day you enroll, provided you enroll within 31 days after you become eligible. Otherwise, satisfactory evidence of insurability must be approved by the insurance company before coverage can begin.
Special Accident Insurance	On the first day of the month after you enroll (PGU bargaining unit employees only).
Business Travel Accident Insurance	On your first day of work.
401(k) Savings Plan	Your contributions in the form of payroll deductions will begin as soon as administratively possible after you enroll, generally within 31 days.
Pension Plan (Closed to new hires)	On your first day of work.

When You May Change Your Elections

You may add or change coverage for Basic Life, Accidental Death and Dismemberment, and GUL (including Spouse and Child life) insurance with an approved statement of health. If eligible, you may add or change Special Accident Insurance at any time. You may cancel these coverages at any time. You may change most 401(k) Savings Plan elections at any time by contacting the 401(k) Savings Plan Recordkeeper, either by phone or online. There are limited circumstances under which you may change other benefit elections.

Other election changes can be made annually during the Open Enrollment period, or within 31 days of a Qualifying Life Event or qualifying significant change in cost or in coverage.

You are obligated to submit proof of dependent status for a Spouse and Child(ren), which includes a birth certificate, Social Security card, marriage certificate, and/or other documents needed to prove eligibility.

If you would like to request a mid-year election change because of a Qualifying Life Event, you must complete a change form and return it to the Pantex Benefits Office within 31 days of the event.

You may enroll a newborn or newly adopted Child for **dental** coverage at any time until the Child is one year of age. Otherwise, the Child can only be enrolled during Open Enrollment.

Reference to a 31-day time limit in this book means calendar days. The 31-day period begins on the day of the event and ends 30 days thereafter. Holidays and weekends are included in the 31-day period. Elections must be received in the Pantex Benefits Office by close of business on day 31 in order to be accepted. Reference to a 61-day time limit in this book means calendar days. The 61-day period begins on the day of the event and ends 60 days thereafter. Holidays and weekends are included in the 61-day period.

Changes at Other Times

Qualifying Life Events

You may change your elections for before-tax medical, dental, and vision contributions, as well as your Flexible Spending Account contribution elections, during the year only on account of and consistent with a Qualifying Life Event or when certain significant changes in cost or in coverage happen. A request to add coverage must be made within 61 days of the Qualifying Life Event. A request to drop coverage must be made within 31 days of the Qualifying Life Event.

A Qualifying Life Event includes:

- Marriage, legal separation, annulment, or divorce
- The death of your Spouse or Child
- The birth or adoption (or placement for adoption) of a Child
- Court-appointed permanent guardianship of a Child
- The loss or gain of benefit eligibility of your Child
- The termination or commencement of employment of you, your Spouse, or Child
- Reduction or increase in hours of employment of you, your Spouse, or Child, including a switch between part-time and full-time, a strike or lockout, or commencement of or return from unpaid leave of absence
- A change in health coverage due to your Spouse's employment
- A "Special Enrollment Period" under the group health plan as required by law
- A Qualified Medical Child Support Order that requires your Child to be covered under the group medical, vision, and/or dental plan
- You, your Spouse, or Child becomes eligible (or loses eligibility) for Medicare or Medicaid
- Involuntary loss of other group health plan coverage

If a dependent add request is received beyond 31 days but within 61 days, coverage is effective the first day of the month following the date the enrollment form is received. If this happens, you will experience up to a 3-month lapse in coverage. Otherwise, you will have to wait until Open Enrollment to enroll the dependent, and the coverage will not be effective until the next January 1.

Birth of a Child:

A newborn Child of an Employee is automatically covered under the medical plan for 31 days. You must complete the Child's enrollment through the Pantex Benefits Office within 31 days of the end of the state-mandated coverage to continue to cover the newborn. Newborns are added the effective date of birth, if enrollment is received within 31 days of the date of birth. If enrollment is received beyond 31 days but within 61 days, coverage will be effective the first day of the month following the date the enrollment form is received. You will experience a one-month lapse in coverage if this occurs.

ↀ REMINDER: Enrollment must be completed AND submitted to the Pantex Benefits Office within 31 days of any Qualifying Life Event.

Below are examples of election changes that are consistent with a Qualifying Life Event

Example of Election Changes Consistent with a Qualifying Life Event	
With this Qualifying Life Event	**You can make these changes, if consistent***
Marriage, birth, adoption, or placement for adoption of a Child	Add yourself, your Spouse, and/or Child(ren); drop coverage if you are to be covered by your Spouse's plan
Divorce, legal separation, or annulment (**Note:** You must cancel coverage for an ex-Spouse within 31 days of divorce. He/she is no longer an Eligible Dependent under the Company's plans.)	Drop your Spouse and/or Children; add coverage if you had been covered under your Spouse's plan
Death of you, your Spouse, or a Child	Drop coverage for Spouse or Child; add coverage if you had been covered by your Spouse's employer
Involuntary loss of other group medical coverage	Add coverage
Your Child ceases to be a dependent (due to age)	Drop dependent coverage
* For your election to be effective, the Plan Administrator must determine that your requested mid-year change is consistent with the Qualifying Life Event. You are obligated to submit proof of dependent status for Child(ren) and your Spouse, which includes a birth certificate, Social Security card, marriage certificate, and/or other documents needed to prove eligibility.	

Changes in Cost or Coverage

In addition, if there is a significant change in the cost of coverage of a benefit option, you may be entitled to make a corresponding change in your election within 31 days of the event (except with respect to the health care spending account). If a new benefit option is added or significantly improved or is curtailed by the Company or by your dependent's employer, you may be permitted to make a corresponding new election. Changes to your health care spending account are not allowed by law for these reasons.

If you contribute to the Dependent Care Flexible Spending Account and there is a significant increase or decrease in the cost of services by a day care provider who is not your relative, you may be able to make corresponding changes to your contribution election for your Dependent Care Spending Account by submitting a new election within 31 days of the change. If your dependent care provider changes or services are significantly curtailed, you may be able to change your election within 31 days.

For example, if mid-year your mother will begin taking care of your Child at no cost and you no longer need your current dependent care center, you can revoke your election to contribute to the Dependent Care Spending Account due to a significant change in coverage. However, if your mother wants a raise mid-year, you cannot increase your contributions to this account due to a change in cost because she is your relative.

In addition, if annual enrollment for your Spouse is for a period of coverage other than the calendar year, you may be permitted to make a corresponding election change under this plan during your Spouse's enrollment period. For example, if you elect family medical coverage and in May your Spouse elects coverage under his or her employer plan for their plan year covering May 1 – April 30, you may drop your Spouse from our medical plan by submitting an election change by May 31.

Please be aware that if the cost of a benefit option that you pay on a pre-tax basis increases or decreases during a year (but not significantly), your election will be automatically changed to reflect the change in the cost of coverage.

How Changes Affect Your Benefits

Steps to Take If You Get Married or Divorced

If You Get Married ...

- Notify the Pantex Benefits Office and your Company's Personnel Security Department to update your personnel records.
- Review your Spouse's benefits so you can coordinate coverage to your best advantage. If you are adding your Spouse to your medical, dental, and/or vision coverage, a copy of your marriage certificate, as well as a copy of his/her Social Security card is required.
- Change your benefit elections within 31 days of your marriage.
- Consider increasing your contributions to the Health Care Flexible Spending Account, or, if you have elected the Choice Fund HSA, your Health Savings Account, so you can pay for your Spouse's unreimbursed medical, dental, and vision expenses with before-tax dollars.
- Update your Life and Accident Insurance beneficiary records.
- Update your 401(k) Savings Plan beneficiary records. Keep in mind that if you are married, your Spouse is your Beneficiary unless you have been designated otherwise with your Spouse's written and notarized consent. Contact the 401(k) Savings Plan Recordkeeper for more information.

If You Get Divorced or Legally Separated ...

- Notify the Pantex Benefits Office and your Company's Personnel Security Department to update your personnel records.
- Change your benefit elections within 31 days after the date your divorce or legal separation is final. You must submit a copy of the final divorce or legal separation decree in order to drop coverage for your ex-Spouse. Your ex-Spouse is eligible to continue medical, dental, and vision coverage for up to 36 months through COBRA. You or your ex-Spouse have 60 days to notify the Pantex Benefits Office in order to obtain COBRA benefits. See the "Administrative Information" section.
- You may also add your Eligible Dependents to your medical, dental, and vision coverage if a court establishes that you must provide coverage for dependent Children who previously had coverage provided by your ex-Spouse. You must provide sufficient documentation to establish dependent eligibility and receive approval through the Pantex Benefits Office.
- Evaluate Life Insurance coverage.
- Update your Life Insurance and Accident Insurance beneficiary records. Beneficiary forms are available from the Pantex Benefits Office.
- Contact the 401(k) Savings Plan Recordkeeper for more information about updating your Beneficiary.
- Contact the Pantex Benefits Office if you think a court may issue a Qualified Domestic Relations Order (QDRO) granting your former Spouse the right to receive any pension or 401(k) Savings Plan benefits. You will be sent important information about the procedures and requirements for QDROs.
- Call the Employee Assistance Program if you need help with a personal, family, or marital problem.

Steps to Take If You Are Expecting or Adopting a Child

You should contact the Pantex Benefits Office to ask about the steps that should be taken, and the deadlines that must be met in order to add a newborn or adopted Child to your coverage. Notify your supervisor and the Pantex Benefits Office for guidance on Family Medical Leave Act options.

When Your Child Arrives

- A newborn Child of a covered participant is automatically covered under the medical plan for 31 days.
- Enroll your newborn or newly adopted Child for medical, dental, and vision benefits within 31 days so your Child's medical expenses will be covered from the date of birth or adoption. You must provide a copy of the Child's birth certificate, Social Security card, and legal documentation for adoption. Call the Pantex Benefits Office for additional guidance on how to add your newborn or adopted Child.
- Consider beginning or increasing your contributions to the Flexible Spending Accounts, or, if you have elected the Choice Fund HSA, your Health Savings Account, so you can pay for your Child's unreimbursed medical expenses and Child care expenses with before-tax dollars.
- Evaluate Life Insurance coverage.
- Update your Life Insurance and Accident Insurance beneficiary records as needed.

YOU MUST COMPLETE AND RETURN ENROLLMENT FORMS WITHIN 31 DAYS OF THE BIRTH OF YOUR CHILD TO ENSURE CONTINUOUS COVERAGE.

Steps To Take If You Become Disabled

If You Become Disabled and Cannot Work ...

- Notify your supervisor, either in person or by telephone, in advance if you cannot report to work. If you cannot reach your supervisor, notify the Plant Shift Superintendent.
- Contact the Pantex Absence Management Group to initiate a disability claim. See Contact Information.
- Comply with requests for information from the Pantex Absence Management Group as long as you are away from work.
- Receive Short-Term Disability benefits for up to six months of disability (if eligible). If your disability continues longer than six months or 26 weeks, you can apply for Long-Term Disability benefits. The Pantex Absence Management Group will provide you with information on how to apply.
- Complete application for Long-Term Disability benefits and provide physician's information as requested by the Long-Term Disability vendor. Claim forms will be provided to you by the Long-Term Disability vendor.
- Apply for any other disability benefits that may be payable (such as Social Security, Workers' Compensation, state or individual disability benefits, and auto insurance recoveries).

The terms "Short-Term" and "Long-Term Disability" are defined in the "Disability" section.

What Happens to Your Benefits If You Become Disabled

- **Medical (Including Prescription Drugs), Dental, and Vision**
  - During Short-Term Disability, coverage continues. Contributions are deducted from your disability benefits if available. Otherwise, you will be invoiced for any outstanding contributions.
  - During Long-Term Disability, Pantex Employees eligible for retirement may continue medical coverage for up to 10 years or age 65 whichever is earlier. For Pantex Employees not eligible for retirement, medical coverage may be continued under COBRA provisions.
- **Employee Assistance Program**
  - During Short-Term Disability, you may continue to access the services of the Employee Assistance Program.
  - During Long-Term Disability, participation ends unless you elect to continue coverage under COBRA provisions.
- **Health Care Spending Account**
  - During Short-Term Disability, participation continues as long as you make contributions. Claims may be submitted for expenses incurred during the period of your disability.
  - During Long-Term Disability, participation ends unless you elect to continue contributing for the rest of the calendar year on an after-tax basis through COBRA.
- **Dependent Care Spending Account**
  - During Short-Term Disability, participation continues as long as you make contributions. Claims may be submitted for expenses incurred while you are actively at work before or after your disability and during the first two weeks of your disability if you are unable to care for your Eligible Dependent.
  - During Long-Term Disability, participation ends.
- **Short-Term and Long-Term Disability**
  - Short-Term Disability provides benefits for up to six months or 26 weeks of disability, depending on your length of service.
  - Long-Term Disability benefits are determined as a percentage of your monthly Pay. Depending upon your employee classification, the Long-Term Disability benefit may be offset by Social Security and other payable benefits. Eligibility for benefits is defined in the "Disability Coverage" section.
- **Basic Life Insurance and Accidental Death and Dismemberment Insurance**
  - During Short-Term Disability and Long-Term Disability, coverage continues at the level in effect at the time your disability began as long as you meet the disability requirements of the Basic Life and AD&D Insurance plans, or until you reach age 65.
- **Group Universal Life (including Spouse and Child Life Insurance)**
  - Coverage continues as long as you pay any applicable premiums to the vendor.
- **Business Travel Accident Insurance**
  - During Short-Term Disability and Long-Term Disability, coverage ends. However, if within 100 days of a covered accident you become totally and permanently disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment of four times your annual Pay after you have been totally and permanently disabled for 12 consecutive months.

- **Special Accident Insurance (PGU Bargaining Unit Employees Only)**
  - During Short-Term Disability, coverage continues.
  - During Long-Term Disability, coverage continues up to 12 months provided you pay the premiums.
- **Pension Plan**
  - During Short-Term Disability, any required employee contributions to the Pension Plan continue.
  - During Long-Term Disability, required employee contributions will cease.
- **401(k) Savings Plan**
  - During Short-Term Disability, contributions continue.
  - During Long-Term Disability, contributions cease. In case of total disability, you become 100% vested in all available funds.

Steps to Take If You Leave the Company

If You Leave the Company ...

- Notify your supervisor.
- You may apply for COBRA within 60 days of your termination if you wish to continue medical (including prescription drugs), dental, and vision coverage or to continue participation in the Health Care Flexible Spending Account.
- You may convert your Basic Life Insurance to a private policy within 30 days of your termination if you wish to continue this type of coverage. Your Basic Life and AD&D coverage is also portable.
- Contact MetLife for information on continuing your Group Universal Life Insurance.
- Decide whether to leave your account balance in the 401(k) Savings Plan, rollover to another qualified plan, or take a distribution.
- Notify the Pantex Benefits Office if your address changes.

What Happens to Your Benefits If You Leave the Company

- **Medical (Including Prescription Drugs)**

Coverage ends on the last day of the month in which your employment terminates. You or your dependents may continue coverage for up to 18 months through COBRA, unless you are discharged for gross misconduct.

- **Dental**

Coverage ends on the last day of the month in which your employment terminates. However, additional benefits may be payable, if you are undergoing a course of treatment at the time of termination. In addition, you or your dependents may continue coverage for up to 18 months through COBRA, unless you are discharged for gross misconduct.

- **Vision**

Coverage ends on the last day of the month in which your employment terminates. You or your dependents may continue coverage for up to 18 months through COBRA, unless you are discharged for gross misconduct.

- **Employee Assistance Program**

Coverage ends upon termination. You or your dependents may continue coverage for up to 18 months through COBRA, unless you are discharged for gross misconduct.

- **Flexible Spending Accounts**

Coverage ends upon termination. You may submit Health Care Spending Account claims and Dependent Care Spending Account claims for expenses incurred before your termination. You may continue your Health Care Spending Account participation on an after-tax basis through the end of the calendar year of the COBRA event, and submit claims for expenses incurred during the period you continue to make contributions.

- **Disability**

Coverage ends upon termination.

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

Coverage ends upon termination. You may convert your Basic Life and Special Accident Insurance to individual policies. Basic life and AD&D Insurance coverage is portable.

- **Group Universal Life Insurance**

Coverage ends upon termination. Contact MetLife for information on continuing your Group Universal Life Insurance after termination.

- **Pension Plan**

Employee contributions, if applicable, will end upon termination. You will receive benefits if you are vested in the Pension Plan.

- **401(k) Savings Plan**

Contributions end upon termination. You may choose to receive a payout of your full vested account balance, rollover to another qualified plan, or you may leave it in the 401(k) Savings Plan. Any outstanding loans must be paid within plan requirements. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Your 401(k) Savings Plan distribution is subject to a mandatory 20% tax withholding unless it is paid as a direct rollover into an individual retirement account or another qualified plan within 60 days.

Contact the 401(k) Savings Plan Recordkeeper for additional information.

Steps to Take If You Retire
If You Are About to Retire ...

- Notify your supervisor.
- If you are pension eligible, call the Pantex Benefits Office to receive retirement counseling and complete necessary forms to initiate your pension benefit.
- If you retire before age 65 and are eligible to continue post-retirement benefits, you may elect medical (including prescription drugs), dental, and vision coverage. If you retire at age 65 or later, you may enroll in the post 65 dental, and post 65 vision plans. You must make your benefit elections immediately upon retirement.
- Call the 401(k) Savings Plan Recordkeeper for information on how to take a full or partial distribution of your vested account balance, rollover your funds to another qualified plan, or leave your account balance in the 401(k) Savings Plan. Any outstanding loans must be paid within plan requirements. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.
- Contact your Social Security office for an estimate of your benefits and information about Medicare if you or your Spouse is age 65 or older.

Medicare Eligibility and Retirement

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

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

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

How does my other insurance work with Medicare?

When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have **retiree** insurance (insurance from your or your Spouse's former employment), Medicare pays first.

If you are 65 or older, have group health plan coverage based on your or your Spouse's **current** employment, and the employer has **20 or more employees,** your group health plan pays first.

If you are 65 or older, have group health plan coverage based on your or your Spouse's **current** employment, and the employer has **fewer than 20 employees,** Medicare pays first.

If you are under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees,** your group health plan pays first.

If you are under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees,** Medicare pays first.

If you have Medicare because of End-Stage Renal Disease (ESRD), your group health plan will pay first for the first 30 months after you become eligible to enroll in Medicare. Medicare will pay first after this 30-month period

For additional Medicare information, please review the Medicare and You Handbook located here: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

What Happens to Your Benefits If You Retire and are Eligible for Pension and Post-Retirement Benefits

Medical (Including Prescription Drugs), Dental, and Vision

If you had at least 10 years of full-time service under the Pension Plan and were at least age 55 at the time of your retirement, you may elect to continue coverage for yourself and your Eligible Dependents. You must pay any cost required by the Company for the continued coverage.

- **Non-bargaining and MTC:**

  When you reach age 65, coverage ends at the end of the month. You may elect to continue coverage under the plans for an enrolled younger Spouse and other enrolled Eligible Dependents for a maximum of 10 years from your retirement date or your Spouse's 65th birthday, whichever is earlier. If your Spouse reaches age 65 before you, you may continue coverage for the Spouse through the end of the month of your Spouse's 65th birthday.

  Effective January 1, 2026: Coverage ends at the end of the month prior to your 65th birthday. You may elect to continue coverage under the plans for an enrolled younger Spouse and other enrolled Eligible Dependents for a maximum of 10 years from your retirement date or your Spouse's 65th birthday, whichever is earlier.

- **PGU:**

  Coverage ends the end of month prior to your 65th birthday. You may elect to continue coverage under the plans for an enrolled younger Spouse and other enrolled Eligible Dependents for a maximum of 10 years from your retirement date or your Spouse's 65th birthday, whichever is earlier. If your Spouse reaches age 65 before you, you may continue coverage for the Spouse until the end of the month prior to your Spouse's 65th birthday.

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

You and your Spouse may be eligible for post-65 dental and/or post-65 vision coverage at age 65 or over if participating in the Company's pre-65 dental and/or pre-65 vision coverage, respectively. See the Pantex Retiree Book of Benefits for more information.

Employee Assistance Program

Coverage ends upon retirement.

Flexible Spending Accounts

You may continue to contribute to the Health Care Spending Account on an after-tax basis until the end of the calendar year of the COBRA event, which is your retirement effective date. Participation in the Dependent Care Spending Account ends upon retirement.

You may submit Health Care Spending Account claims for eligible expenses incurred after you retire only if you continue under COBRA provisions.

Disability

Coverage ends upon retirement.

Basic Life Insurance

Life Insurance coverage may be converted to a personal policy in accordance with plan provisions.

Accidental Death and Dismemberment (AD&D) Insurance

Coverage ends upon retirement; however, the Plan has a portable feature you may elect.

Group Universal Life Insurance (including Spouse and Child Life Insurance)

Coverage ends upon retirement. Contact MetLife for information on continuing your Group Universal Life Insurance.

Pension Plan

Employee contributions, if applicable, will end upon retirement. You will receive benefits if you are vested in the Pension Plan.

Business Travel Accident Insurance

Coverage ends upon retirement.

Special Accident Insurance (PGU Bargaining Unit Only)

Coverage ends upon retirement; however, you may convert your coverage to a personal policy.

401(k) Savings Plan

Contributions end upon retirement. You may choose to receive a full or partial distribution of your vested account balance, rollover your funds to another qualified plan, or you may leave it in the 401(k) Savings Plan. Any outstanding loans must be paid within plan requirements. Otherwise, the outstanding loan balance will be treated as a taxable distribution to you.

Your 401(k) Savings Plan distribution is subject to a mandatory 20% tax withholding unless it is paid as a direct rollover into an individual retirement account or another qualified plan within 60 days.

Contact the 401(k) Savings Plan Recordkeeper for additional information.

Steps To Take If You or a Family Member Dies

In the Case of Your Death ...

- A family member should notify the Pantex Benefits Office of your death.
- The Pantex Benefits Office will provide guidance to your appropriate family member(s) on the applicable documents for initiating benefits that may be available as a result of the death.
- Your designated Beneficiary should complete a Life Insurance and/or Special Accident Insurance claim forms. The completed forms with a certified death certificate and other supporting information should be sent to the Pantex Benefits Office.
- If available, a family member may convert any family Special Accident Insurance coverage to a personal policy within 30 days of the death if they wish to continue this coverage.
- The Beneficiary should contact the insurance company for information on filing a claim and/or continuing Group Universal Life Insurance coverage.
- Eligible Dependents should decide whether to continue medical, dental, and vision coverage. The cost and the length of continuation will be based upon your full-time service at the time of death.
- Remember, the Employee Assistance Program is available to family members who may need counseling.

If Your Spouse or Dependent Dies ...

- Notify the Pantex Benefits Office.
- Contact the insurance company for information on filing a Group Universal Life claim, if applicable.
- Complete a Special Accident Insurance claim form if you are enrolled for family Special Accident Insurance coverage and the death was accidental. Send the completed form(s) with a certified death certificate and other supporting information to the Pantex Benefits Office.
- Change your medical (including prescription drugs), dental, vision, Flexible Spending Account, Life, and Special Accident Insurance elections within 31 days of the death.
- Review your Beneficiary elections for Life and Accident Insurance and the 401(k) Savings Plan.

Remember, the Employee Assistance Program is available if you or your family members need counseling.

What Happens to Your Benefits If You Die

- **Pantex Medical (Including Prescription Drugs), Dental, and Vision**
  - Your Spouse and Eligible Dependents may continue coverage at the appropriate active employee cost for three months immediately following your death.
  - If you had at least 10 years of full-time service under the Pension Plan and were at least age 55 at the time of your death, your Spouse may elect pre-65 retiree coverage for himself/herself and Eligible Dependents. The Spouse must pay any cost required by the Company for the continued coverage.
  - When your Spouse reaches age 65, coverage ends.

- Dependent Child(ren) coverage ends when your Spouse is no longer eligible for the pre-65 retiree plans. They may be eligible to continue coverage under COBRA.
- If you were not retirement eligible at the time of your death, your Eligible Dependents may continue coverage for a three-month period at appropriate active employee cost. An additional 33 months of coverage is available through COBRA. See the "Administrative Information" section for more information.

- **Employee Assistance Program**
- Coverage ends upon death.

- **Flexible Spending Accounts**
- Participation ends upon death. Dependents may submit claims for health care and dependent care expenses incurred before your death.

- **Basic Life and Accidental Death and Dismemberment (AD&D) Insurance**
- In accordance with plan provisions, your Beneficiary(ies) may receive benefits based upon the coverage you elected.

- **Pension Plan**
- Employee contributions, if applicable, will end upon death.
- If you are vested in the Pension Plan, the Pantex Benefits Office will contact your Spouse regarding any benefits that may be payable.

- **401(k) Savings Plan**
- Your Beneficiary may receive your full account balance in a lump sum, or other options may be available. Contact the 401(k) Savings Plan Recordkeeper for additional information.
- Keep in mind that if you are married, your Spouse is your Beneficiary unless you have designated otherwise with your Spouse's written and notarized consent.

Current Employees

The medical, dental, and vision coverage before-tax medical, dental, and vision premiums, and Flexible Spending Account elections you make during the fall Open Enrollment period will be effective on January 1 of the following year.

If you change your elections because of a Qualifying Life Event, the changes will be effective as described below under "Paying for Your Benefits."

Paying for Your Benefits

If you elect to pay for coverage on a pre-tax basis, the IRS restricts when pre-tax contributions may begin or end during the plan year. Therefore, the required contributions for coverage you elect to purchase with pre-tax dollars will be deducted as follows.

- For initial elections made within 31 days of your date of hire, the pre-tax deductions will begin on the payroll following the date your election is processed. Any payments due for coverage from the date your coverage is effective until the date pre-tax deductions begin will be deducted on an after-tax basis.
- For elections made for a Qualifying Life Event other than the birth, adoption, or placement for adoption of a Child, the pre-tax deductions will begin on the payroll following the date your election is processed. Any payments due for coverage from the date of the Qualifying Life Event until the date pre-tax deductions begin will be deducted on an after-tax basis.
- For elections made within 31 days of the birth, adoption, or placement for adoption of a Child, all payments required for coverage from the date of such event will be deducted on a pre-tax basis.

With the exception of 401(k), pre-tax payroll deductions can only be changed if you have a Qualifying Life Event and you contact the Pantex Benefits Office within the time specified in the Qualifying Life Event section of this handbook. Therefore, if you have a Qualifying Life Event and you do not notify the Pantex Benefits Office within the time specified of the Qualifying Life Event, you may have a change in coverage level but no change in premium until the following year.

Before-Tax or After-Tax?

Before-tax contributions offer special tax advantages. You do not pay federal, Medicare, Social Security, and in most cases, state or local income taxes on the before-tax Pay you use for buying medical, dental, or vision coverage or for participating in the Flexible Spending Accounts. This is also true for before-tax 401(k) Savings Plan contributions, except Medicare and Social Security taxes will apply.

Even though before-tax contributions reduce your Pay for income tax purposes, the Company will continue to recognize your full basic rate of Pay for your other Pay-related benefits, such as Life Insurance, Disability Coverage, and Pension Benefits.

Rights and Responsibilities

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

In order to participate in the plans, you must allow the Company to use your individual information (such as address and phone numbers, including private phone numbers, or whatever is minimally necessary to fully administer any and all benefit plans). The Company will share your individual information with third-party vendors only to the extent minimally necessary to support the administrative processes and features of the benefit plans. Vendor and service contracts will be maintained that exclusively limit the use of your individual information to the operation of the specific benefit program for which the vendor provides service.

Health plans such as medical and prescription drugs may include managed care, disease or wellness management, and utilization management programs which are incorporated programs of the benefit plan. The Company reserves the right to incorporate these management programs into the benefits plans offered.

When Coverage Ends

Unless otherwise noted, coverage under the Company's benefit plans will end on the earliest of the following dates.

- The date your employment terminates, with these exceptions:
  - For medical (including prescription drugs), dental, and vision coverage, the last day of the month in which your employment terminates
  - For Long-Term Disability coverage, the date your employment terminates for any reason, unless you are totally disabled
  - The date you are no longer considered eligible because of a change in your employment status, including a reduction in hours
  - The last day of the period for which your last contribution was made (if you fail to make any required contribution)
  - The date the Plan is terminated

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

If your coverage ends, you may be eligible to extend medical (including prescription drugs), dental, and vision coverage, as well as Health Care Spending Account participation under COBRA.

Your participation in the 401(k) Savings Plan may continue (with some limitations) after you stop making contributions.

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Medical Plan

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Your Medical Benefits

Your medical benefits offer coverage under the following Cigna Plans:

- Available to Pantex Guards Union (PGU):
  - Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
  - Cigna Open Access Plus (OAP) PGU Preferred Provider Organization (PPO) Core Plan
  - Cigna Open Access Plus (OAP) PGU Preferred Provider Organization (PPO) Select Plan
- Available to Metal Trades Council (MTC) and Pantex Non-Bargaining:
  - Cigna Open Access Plus (OAP) Choice Fund with Health Savings Account (HSA) Plan
  - Cigna Open Access Plus (OAP) Preferred Provider Organization (PPO) Core Plan
  - Cigna Open Access Plus (OAP) Preferred Provider Organization (PPO) Select Plan
- If you temporarily reside outside of Texas, and Cigna has a local open access network available, you may be provided use of that network and receive In-Network benefits.
- If you reside in an area where a Cigna network is not available:
  - Cigna Indemnity Plan
- Cigna has discretion to determine network availability.
- You may also choose to waive coverage. If you initially waive coverage, you may enroll during the next Open Enrollment period or when you experience a Qualifying Life Event, as described within the "About Your Benefits" section.
- Your Cigna plan will also provide protection and coverage for your Eligible Dependents under the same plan in which you are enrolled.

For more information about what happens to your medical benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section. For more information about Prior Authorization, Covered Expenses, Exclusions, Expenses Not Covered, General Limitations and Medical Necessity, refer to the Cigna plan design documents available at https://pxhome.pantex.doe.gov/employee-benefits/index.php which are incorporated by reference into this SPD.

Open Access Plus (OAP) Plans

How the Open Access Plus Plans Work

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

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

When you select a Participating Provider, these Plans pay a greater share of the costs than if you select a Non-Participating Provider. Participating Providers are In-Network Primary Care Physicians (PCPs) who are family or general practitioners, internists, and pediatricians who contract with Cigna to provide their services and charge only the contracted fee amount. Consult the Cigna website for a list of Participating Providers in your area. Participating Providers are committed to providing you and your dependents appropriate care while lowering medical costs. A PCP is generally responsible for coordinating all health care. In-Network PCPs and specialists also handle all inpatient and outpatient precertification.

For maximum coordination of your medical care, it is recommended that you choose a PCP. You are not required to choose a PCP or obtain a referral from a PCP in order to receive available benefits to you under these Plans. However, a PCP may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Eligible Dependents. For this reason, we encourage the use of PCPs and provide you with the opportunity to select a PCP from a list provided by Cigna for yourself and your Eligible Dependents. The PCP you choose for yourself may be different from the PCP you select for each of your Eligible Dependents.

You may select a new PCP by contacting Cigna at the member services number on your identification (ID) card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed. In addition, if at any time a PCP ceases to be a Participating Provider, you or your Eligible Dependents will be notified for the purpose of selecting a new PCP. For information on how to select a PCP, and for a list of the participating PCPs, visit www.myCigna.com or contact Cigna customer service at 1-877-774-9913.

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early, when they are less expensive to treat and you are more likely to fully recover. A PCP will provide a full range of preventive care based on recognized medical guidelines for your age, gender, and personal and family health histories. This care includes the following:

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

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

Under the OAP Plans:

- You do not need a referral to receive covered services from any participating specialist, but you may want your PCP's advice and assistance in arranging care with a specialist in the network. If you choose to see an Out-of-Network specialist, the health care services you receive will be covered at the Out-of-Network level.
- You do not need prior authorization from the Plan or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or making referrals.
- For an Emergency, you will need to call your PCP within 48 hours after the Emergency to ensure In-Network benefits and have your PCP coordinate any follow-up care.

Deductibles, Copayments, and Coinsurance

You and your Eligible Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible, Copayment, or Coinsurance:

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

For Deductibles, Copayments, or Coinsurance amounts, refer to the Summary of Benefits for your plan.

If You Have an Emergency

If you have an Emergency, go to the nearest emergency facility for treatment. You must contact your PCP or Cigna member services within 48 hours of your Emergency treatment to ensure In-Network benefits are paid and to arrange for follow-up care.

If the situation is urgent, but not an Emergency, you should contact your PCP first and follow his or her directions or go to an In-Network Urgent Care facility.

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

If you need care while traveling outside your network area

You are covered for Emergency care or Urgent Care on an In-Network basis, as long as you call your PCP or Cigna member services within 48 hours of receiving Emergency or Urgent Care. (If you are traveling outside the U.S., you may wait until you return home to contact your PCP. You must file a paper claim for reimbursement as soon as possible when you return).

The Network Credentialing Process

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

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

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

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

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

Case Management

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

Multiple Surgical Reduction

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

Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply or on a percentage of a schedule based on a methodology similar to one used by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare-based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of one of the following:

- the provider's normal charge for a similar service or supply, or
- the charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the insurance company.

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

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

Out-of-Network Benefits

When you go Out-of-Network, you can use any physician or facility you like. After you meet an annual Deductible, the Plan pays the Maximum Reimbursable Charge for most kinds of Medically Necessary services until the annual Out-of-Pocket Maximum has been reached.

The Out-of-Pocket Maximum protects you by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the Out-of-Pocket Maximum, the Plan pays 100% of the Maximum Reimbursable Charge for the remainder of that year.

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

Pre-Certification Requirements

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

If services are provided In-Network, you do not have to worry about pre-certification. Your In-Network PCP or specialist will handle it for you. But, if you go Out-of-Network for care, you are responsible for calling Cigna member services at least seven days, or as soon as possible, before you are admitted to the hospital or receive outpatient diagnostic testing or procedures. If you do not call, your benefit will be reduced.

When you call Cigna member services for pre-certification, you need to provide the following information:

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

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

Preadmission Certification (PAC)/ Continued Stay Review (CSR) for Hospital Confinement

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

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

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

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

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

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

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements

Outpatient Certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and outpatient procedures, including but not limited to, those listed in this section when performed as an outpatient in a free-standing surgical facility, other Health Care Facility, or a physician's office.

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

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

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

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed but that were not certified as Medically Necessary.

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

Diagnostic Testing and Outpatient Procedures

Diagnostic tests and outpatient procedures that require certification include, but are not limited to, Advanced Radiological Imaging (e.g., CT scans, MRI, MRA, or PET scans) and hysterectomy.

Emergency Hospitalization

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

Filing Claims

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

To file a claim for Out-of-Network treatment under the Open Access Plus (OAP) plans or for any treatment under the Indemnity plan, you must complete a claim form and send it to Cigna within 90 days after the plan year in which services have been rendered.

Be sure to do the following:

- Include the account number listed on your ID card.
- Use a separate form for each Covered Dependent.
- Indicate whether you would like reimbursement of a payment you have made sent to you. Otherwise, it will be sent to the provider.

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

- Patient's full name, date of birth, and relationship to you
- Physician's full name, address, and tax identification number
- Diagnosis code
- Date and charge for each service

Claim forms can be obtained from Cigna member services or the Pantex Benefits Office.

Coordination of Benefits

If you or any of your Eligible Dependents are covered under another medical plan, Cigna determines how benefits from all such plans will be coordinated.

Medical Insurance after Age 65 – During Active Service

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

- **Continue primary coverage under the Company medical plan**. In this case, the Plan will pay benefits first. Your Spouse and/or dependents can continue coverage under the Company plan, as well. It is recommended; however, that you or any Medicare-Eligible Dependents enroll in Medicare Part A when eligible.
- **Cancel company health coverage and elect primary coverage under Medicare**. Should you elect this option, you should first compare benefits and costs of employer coverage and Medicare. If you are considering traditional Medicare, consider costs for Part B, a Part D prescription drug plan, and a Medigap supplemental insurance plan.
- With either election, please consult your Social Security office for additional guidance.

Company Right to Reimbursement (Subrogation)

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

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

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

Mental Health/Alcohol and Substance Abuse Treatment

Under the Cigna OAP Plans, you must have mental health/alcohol and drug abuse treatment reviewed and authorized by calling the number listed on your ID card.

If you prefer, your PCP, local Employee Assistance Program, or your site's Occupational Health Services department can make the call for you. A PCP referral is not necessary.

Personal Health Team

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

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

Continuation of Medical Coverage (COBRA)

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

Conversion Privileges

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

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

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

Certificate of Creditable Coverage

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

Cigna Member Services

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

- find out more about In-Network PCP, specialists, and facilities
- get more information about plan features and procedures
- change PCP
- order replacement ID cards
- register comments about network providers and services
- request Out-of-Network claim forms

In Addition to Member Services:

You may locate Participating Providers in your Cigna network by accessing www.myCigna.com. Click on the "Provider Directory" link and follow the instructions for locating providers in your area.

As a Cigna member, you have access to your benefit information through your own personalized Cigna website. There you can do the following:

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

If you go Out-of-Network, you must also call Cigna member services for pre-certification.

℗ Contacting Cigna Member Services

Please call 1-877-774-9913 or log on to www.myCigna.com.

Information for All Medical Plans

Newborns' and Mothers' Health Protection Act of 1996

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

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

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

Pantex Guards Union

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Summary of Benefits: Medical Plans

PGU PPO Core

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-Network providers: $250/Individual and $500/Family Out-of-Network providers: $800/Individual and $1,600/Family Individual Deductible applies when the employee is the only person covered under the Plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **Out-of-Pocket Limits** on my expenses?	In-Network providers: $1,500/Individual and $3,000/Family Out-of-Network providers: $3,000/Individual and $6,000/Family	The **Out-of-Pocket Limit** is the most you could pay during a calendar year for your share of the cost of covered services.
What is not included in the O**ut-of-Pocket Limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **Out-of-Pocket Limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Calendar Year Deductible	$250/Individual $500/Family	$800/Individual $1,600/Family
• The amount you pay for all Covered Expenses counts toward both your In-Network and Out-of-Network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, Covered Expenses for that family member will be paid based on the Coinsurance level specified by the Plan. After the family Deductible has been met, Covered Expenses for each eligible family member will be paid based on the Coinsurance level specified by the Plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all Covered Expenses counts toward both your In-Network and Out-of-Network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the Plan will pay 100% of his or her Covered Expenses. After the family Out-of-Pocket Maximum has been met, the Plan will pay 100% of each eligible family member's Covered Expenses.		

Benefit	Preventive Care	In-Network	Out-of-Network
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.		Plan Pays 100%	Not Covered
Immunizations		Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services		Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after Deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services			
PCP Office **Specialist Office** • All services including Lab and X-ray • Plan Pays 100% after your Copay		You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office		You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Treatment/Injections • PCP Office • Specialist Office		You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)		Plan Pays 100%	Plan Pays 70% after Deductible
Inpatient			
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate		Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Inpatient Hospital Physician's Visit/Consult		Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists		Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Outpatient			
Outpatient Facility Services		Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists		Plan Pays 90% after Deductible	Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation (includes coverage for developmental delays) **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $15 Copay	Plan Pays 70% after Deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after Deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Plan Pays 70% after Deductible
Cochlear Implants	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges. Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 100% Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Lab and X-ray in: • Physician's Office • Specialist Office • Independent Lab • Outpatient Facility **Note:** Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 90% Plan Pays 90%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Advanced Radiological Imaging in: • Physician's Office • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit. **Note 3:** Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $125 Copay Per Visit Plan Pays 100% You Pay $30 Copay Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after Deductible	

Benefit	In-Network	Out-of-Network
Hospice Care and Bereavement Counseling		
• Inpatient Hospital and Other Health Care Facilities	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
• Outpatient Services	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Note: Services provided by mental health professionals are covered under mental health benefits.		
Organ Transplant Coverage		
Includes all medically appropriate, non-experimental transplants		
Inpatient Hospital Facility		
• LifeSOURCE Facility	Plan Pays 100%	Not Covered
• Non- LifeSOURCE Inpatient Facility	Plan Pays 90% after Deductible	Not Covered
Inpatient Professional Services	Plan Pays 100%	Not Covered
• LifeSOURCE Facility	Plan Pays 90% after Deductible	Not Covered
• Non- LifeSOURCE Facility		
Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)		
Maternity		
Initial Visit to Confirm Pregnancy		
• PCP Office Visit	You Pay $20 Copay	Plan Pays 70% after Deductible
• Specialist Office Visit	You Pay $30 Copay	Plan Pays 70% after Deductible
Global Maternity Fee	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
(All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges)		
Office Visits in Addition to Global Maternity Fee	You Pay $20 Copay	Plan Pays 70% after Deductible
Performed by Physician Office	You Pay $30 Copay	Plan Pays 70% after Deductible
Performed by OB/GYN or Specialist		
Delivery Facility	Covered same as Plan's Inpatient Hospital Benefit	Covered same as Plan's Inpatient Hospital Benefit
Inpatient Hospital, Birthing Center		
Abortion – Elective and Non-Elective Procedures		
• PCP Office	You Pay $20 Copay	Plan Pays 70% after Deductible
• Specialist Office	You Pay $30 Copay	Plan Pays 70% after Deductible
• Inpatient Facility	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
• Outpatient Facility	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
• Inpatient Professional Services	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
• Outpatient Professional Services	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Surgical and Non-Surgical Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	You Pay $20 Copay You Pay $30 Copay Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder Inpatient Outpatient – Physician's Office Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 90% after Deductible You Pay $30 Copay Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services

PGU PPO Core

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

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

Pantex Guards Union

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Summary of Benefits: Medical Plans

PGU PPO Select

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

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

Benefit	In-Network	Out-of-Network
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests • Routine services • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after Deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office**	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $25 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after Deductible
Inpatient		
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $200 Copay Per Admission	Plan Pays 70% after Deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after Deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after Deductible
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $100 Copay Per Facility/Visit	Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after Deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $10 Copay	Plan Pays 70% after Deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $10 Copay	Plan Pays 70% after Deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after Deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after Deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after Deductible
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 100%	Plan Pays 70% after Deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary	Not Covered	Not Covered
Hearing Aid • $5,000 maximum In-Network per pair per 36 months • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after Deductible
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges. Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Lab and X-ray in: • PCP Office • Specialist Office • Independent Lab • Outpatient Facility **Note:** Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Advanced Radiological Imaging in: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan You Pay $100 Copay Per Scan	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $100 Copay Per Visit Plan Pays 100% You Pay $25 Copay Per Visit Plan Pays 100%	

Benefit	In-Network	Out-of-Network
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility • Non- LifeSOURCE Inpatient Facility **Inpatient Professional Services** • LifeSOURCE Facility • Non- LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	 $200 Copay Per Visit $200 Copay Per Visit Plan Pays 100% Plan Pays 100%	 Not Covered Not Covered Not Covered Not Covered
Maternity Initial Visit to Confirm Pregnancy • PCP Office Visit • Specialist Office Visit **Global Maternity Fee** All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges **Office Visits in Addition to Global Maternity Fee** PCP Office Visit Specialist Office Visit **Delivery Facility** Inpatient Hospital, Birthing Center	 You Pay $20 Copay You Pay $25 Copay Plan Pays 100% Covered same as Physician Services Office Visit Covered same as Plan's Inpatient Hospital Benefit	 Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Covered same as Physician Services Office Visit Covered same as Plan's Inpatient Hospital Benefit

Benefit	In-Network	Out-of-Network
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $25 Copay You Pay $200 Copay Per Visit You Pay $100 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Men's Services Includes surgical services, such as vasectomy (excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $25 Copay You Pay $200 Copay Per Visit You Pay $100 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $25 Copay You Pay $200 Copay Per Visit You Pay $100 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible

Benefit	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	You Pay $20 Copay You Pay $25 Copay You Pay $200 Copay Per Visit You Pay $100 Copay Per Visit Plan Pays 100% Plan Pays 100%	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient – Physician's Office • Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	You Pay $200 Copay You Pay $25 Copay Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay	Not Covered

Excluded Services
PGU PPO Select

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

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

Metal Trades Council (MTC)

Pantex Non-Bargaining

Pantex Guards Union (PGU)

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Summary of Benefits: Medical Plans

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

The Choice Fund with HSA is a High Deductible Medical Plan. This plan comes with an HSA which is a tax-advantaged bank account that allows you to save and then use tax-free dollars to pay for health care expenses in the months and years ahead.

Any money you and the Company contribute to your HSA will not be taxed. As long as you use your HSA funds to pay for eligible expenses, you will not be taxed. You can make tax-free contributions to your account up to the annual IRS limit. If you are age 55 or older, you can make additional contributions in accordance with IRS limits.

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

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

Your HSA balance is yours to use even if you no longer participate in a High Deductible Plan or leave the Company. The HSA funds are "Portable". They stay with you if you change plans, retire, or terminate employment. When your HSA coverage ends you may still receive tax-free HSA distributions for eligible expenses (or withdraw funds on a taxable basis for ineligible expenses) but you may no longer make tax-free contributions to your HSA account.

Who is not eligible for the HSA:

- If you are currently not enrolled in a high deductible health plan
- You or an Eligible Dependent who is entitled to Medicare
- If you are claimed as a dependent under someone else's tax return

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

Important Questions	Answers	Why this Matters
What is the overall **Deductible**?	In-Network providers: $1,650/Individual and $3,300/Family Out-of-Network providers: $3,300/Individual and $6,600/Family Deductible per person applies when the employee is the only person covered under the Plan.	You must pay all the costs up to the **Deductible** amount before this plan begins to pay for covered services you use.
Are there any **Out-of-Pocket Limits** on my expenses?	In-Network providers: $4,000/Individual and $8,000/Family Out-of-Network providers: $8,000/Individual and $16,000/Family	The **Out-of-Pocket Limit** is the most you could pay during a calendar year.
What is not included in the **Out-of-Pocket Limit**?	Premiums, balanced-billed charges, penalties for no pre-certification, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **Out-of-Pocket Limit**.
Do I need a referral to see a **Specialist**?	No. You do not need a referral to see a **Specialist**.	You can see the **Specialist** you choose.

Plan Highlights	In-Network	Out-of-Network
Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses. Annual Employer Contribution: For **Individual Coverage:** **$250** For **Family Coverage:** **$500**		
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 90%	Plan Pays 70%
Calendar Year Deductible	$1,650/Individual $3,300/Family	$3,300/Individual $6,600/Family
• The amount you pay for In-Network Covered Expenses only counts toward your In-Network Deductible. The amount you pay for Out-of-Network Covered Expenses counts toward both your In-Network and Out-of-Network Deductibles. • The Deductible must be met first before any Copay or Coinsurance will apply. • This plan includes a combined medical/pharmacy plan Deductible. • All eligible family members contribute towards the family plan Deductible. Once the family Deductible has been met, the Plan will pay each eligible family member's expenses based on the Coinsurance level specified by the Plan. **Note 1:** If you cover only yourself in this plan, you need to meet the individual Deductible before the Plan applies any Coinsurance or Copay for covered benefits. **Note 2:** If you cover yourself and any dependents, the family Deductible will apply. You must meet the entire family Deductible before the Plan applies any Coinsurance or Copay for covered benefits (there is no individual Deductible).		
Calendar Year Out-of-Pocket Maximum	$4,000/Individual $8,000/Family	$8,000/Individual $16,000/Family
• The amount you pay for In-Network Covered Expenses only counts toward your In-Network Out-of-Pocket Maximum. The amount you pay for Out-of-Network Covered Expenses counts toward both your In-Network and Out-of-Network Out-of-Pocket Maximums. • All Copays, Coinsurance, and Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After each eligible family member meets his or her individual Out-of-Pocket Maximum, the Plan will pay 100% of his or her Covered Expenses. After the family Out-of-Pocket Maximum has been met, the Plan will pay 100% of each eligible family member's Covered Expenses.		
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered
Mammogram, PAP, and PSA Tests		
• Routine services	Plan Pays 100%	Plan Pays 70% after Deductible
• Non-routine services	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service

Benefits	In-Network	Out-of-Network
Physician Services		
PCP Office	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Specialist Office	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Inpatient		
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Outpatient		
Outpatient Facility Services	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Chiropractic Care Calendar Year Maximum: 25 days	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 90% after Deductible	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 90% after Deductible	Not Covered
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Lab and X-ray **Note:** All lab and X-ray services, including Advanced Radiological Imaging (ARI), provided at Inpatient Hospital are covered under Inpatient Hospital benefit. Emergency Room/Urgent Care Facility are covered the same as Emergency Care/Urgent Care Facility services.	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Advanced Radiological Imaging in: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 90% after Deductible Plan Pays 70% after Deductible
Emergency Care • Outpatient Professional Services **Urgent Care** • Outpatient Professional Services	Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 90% after Deductible Plan Pays 90% after Deductible
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 90% after Deductible	Plan Pays 90% after Deductible
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility • Non- LifeSOURCE Inpatient Facility **Inpatient Professional Services** • LifeSOURCE Facility • Non- LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	Plan Pays 100% after Deductible Plan Pays 90% after Deductible Plan Pays 100% after Deductible Plan Pays 90% after Deductible	Not Covered Not Covered Not Covered Not Covered

Benefits	In-Network	Out-of-Network
Maternity Initial Visit to Confirm Pregnancy	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Global Maternity Fee All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Plan Pays 90% after Deductible	Plan Pays 70% after Deductible
Delivery Facility Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital Benefit	Covered same as Plan's Inpatient Hospital Benefit
Abortion – Elective and Non-Elective Procedures • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Men's Services Includes surgical services, such as vasectomy (excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Benefits	In-Network	Out-of-Network
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder Inpatient Outpatient – Physician's Office Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 90% after Deductible Plan Pays 90% after Deductible Plan Pays 90% after Deductible	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	Plan Pays 90% after Deductible	Not Covered

Excluded Services
Choice Fund HSA

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

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

Metal Trades Council (MTC)

Pantex Non-Bargaining

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Summary of Benefits: Medical Plans

PPO Core

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

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

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

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

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

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

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

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

Excluded Services
PPO Core

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

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

Metal Trades Council (MTC)

Pantex Non-Bargaining

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Summary of Benefits: Medical Plans

PPO Select

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

Benefit	In-Network	Out-of-Network
Maximum Lifetime Benefit	Unlimited	Unlimited
Coinsurance	Plan Pays 100%	Plan Pays 70% after Deductible
Calendar Year Deductible	None	$500/Individual $1,000/Family
• The amount you pay for all Covered Expenses counts toward your Out-of-Network Deductibles. • Copays always apply before plan Deductible and Coinsurance. • After an eligible family member meets his or her individual Deductible, Covered Expenses for that family member will be paid based on the Coinsurance level specified by the Plan. After the family Deductible has been met, Covered Expenses for each eligible family member will be paid based on the Coinsurance level specified by the Plan.		
Calendar Year Out-of-Pocket Maximum	$1,500/Individual $3,000/Family	$3,000/Individual $6,000/Family
• The amount you pay for all Covered Expenses counts toward both your In-Network and Out-of-Network Out-of-Pocket Maximums. • All Copays, Coinsurance, and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the Plan will pay 100% of his or her Covered Expenses. After the family Out-of-Pocket Maximum has been met, the Plan will pay 100% of each eligible family member's Covered Expenses.		
Preventive Care		
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%	Not Covered
Immunizations	Plan Pays 100%	Not Covered

Benefits	In-Network	Out-of-Network
Mammogram, PAP, and PSA Tests • Routine services *subject to the Plan's x-ray benefit & lab benefit; based on place of service. • Non-routine services	Plan Pays 100% Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service	Plan Pays 70% after Deductible Plan Pays subject to Plan's Lab and X-ray benefit; based on place of service
Physician Services		
PCP Office **Specialist Office**	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	You Pay $20 Copay You Pay $30 Copay	Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 100%	Plan Pays 70% after Deductible
Inpatient		
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	You Pay $400 Copay Per Admission	Plan Pays 70% after Deductible
Inpatient Hospital Physician's Visit/Consult	Plan Pays 100%	Plan Pays 70% after Deductible
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after Deductible
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit Copay	You Pay $250 Copay Per Facility/Visit	Plan Pays 70% after Deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 100%	Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation • Includes coverage for developmental delay **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	You Pay $20 Copay	Plan Pays 70% after Deductible
Chiropractic Care Calendar Year Maximum: 25 days	You Pay $20 Copay	Plan Pays 70% after Deductible
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 100%	Plan Pays 70% after Deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Calendar Year Maximum: 60 days	Plan Pays 100%	Plan Pays 70% after Deductible
Durable Medical Equipment • Calendar Year Maximum: Unlimited • Includes coverage for foot orthotics and supportive devices; orthotic shoes	Plan Pays 100%	Plan Pays 70% after Deductible
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan Pays 100%	Not Covered *In-Network coverage only
Enteral Formulas • Nutritional formulas for enteral feedings are covered regardless of diagnosis	Plan Pays 100%	Plan Pays 70% after Deductible
External Prosthetic Appliances (EPA) • Calendar Year Maximum: Unlimited	Plan Pays 100%	Not Covered
Routine Foot Disorders **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary	Not Covered	Not Covered
Hearing Aid • Maximum of 1 pair every 36 months; maximum $3,000 • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Excludes replacement and repair of hearing aid due to normal wear and replacement batteries	Plan Pays 100%	Not Covered
Cochlear Implants	Plan Pays 100%	Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Medical Specialty Drugs Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after Deductible
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	Plan Pays 100%	Plan Pays 70% after Deductible
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's office. This benefit does not cover the related Office Visit or Professional charges.	Plan Pays 100%	Plan Pays 70% after Deductible
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	Plan Pays 100%	Plan Pays 70% after Deductible
Lab and X-ray in: • PCP Office • Specialist Office • Independent Lab • Outpatient Facility **Note:** Emergency Room/Urgent Care Facility lab and X-ray services covered the same as Emergency Room and Urgent Care Facility services.	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Advanced Radiological Imaging in: • Physician's Office • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	You Pay $150 Copay Per Scan You Pay $150 Copay Per Scan You Pay $150 Copay Per Scan	Plan Pays 70% after Deductible You Pay $150 Copay Per Scan Plan Pays 70% after Deductible
Emergency Care • Emergency Room • Outpatient Professional Services	You Pay $150 Copay Per Visit Plan Pays 100%	
Urgent Care • Urgent Care Facility • Outpatient Professional Services **Note:** Copays are waived if admitted.	You Pay $30 Copay Plan Pays 100%	
Ambulance Services If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered.	Plan Pays 100%	

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

Benefits	In-Network	Out-of-Network
Family Planning – Men's Services Includes surgical services, such as vasectomy (excludes reversals) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copy Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Family Planning – Women's Services Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Infertility Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copy Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible

Benefits	In-Network	Out-of-Network
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	You Pay $20 Copay You Pay $30 Copay You Pay $400 Copay Per Visit You Pay $250 Copay Per Visit Plan Pays 100% Plan Pays 100%	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Mental Health and Substance Abuse Disorder Services		
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management: • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs		
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient – Physician's Office • Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	You Pay $400 Copay You Pay $30 Copay Plan Pays 100%	Plan Pays 70% after Deductible Plan Pays 70% after Deductible Plan Pays 70% after Deductible
Telephone or Video Consultations		
Services Provided by MDLive • Telephone consultation • Video/online consultation	You Pay $20 Copay (Urgent/ Primary Care) You Pay $30 Copay (Specialty Care)	Not Covered Not Covered

Excluded Services
PPO Select

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

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Indemnity

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Summary of Benefits: Medical Plan

Indemnity

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

Benefit	Out-of-Area
Maximum Lifetime Benefit	Unlimited
Coinsurance	Plan Pays 80% after Deductible
Calendar Year Deductible	$750/Individual $1,500/Family
• Benefit Deductible always applies before plan Deductible and Coinsurance. • The amount you pay for all Covered Expenses counts toward your Deductible. • After an eligible family member meets his or her individual Deductible, Covered Expenses for that family member will be paid based on the Coinsurance level specified by the Plan. After the family Deductible has been met, Covered Expenses for each eligible family member will be paid based on the Coinsurance level specified by the Plan.	
Calendar Year Out-of-Pocket Maximum	$3,250/Individual $6,500/Family
• The amount you pay for all Covered Expenses counts toward your Out-of-Pocket Maximum. • All Coinsurance and plan Deductibles contribute toward your Out-of-Pocket Maximum. • This plan includes a combined medical/pharmacy plan Out-of-Pocket Maximum. • After an eligible family member meets his or her individual Out-of-Pocket Maximum, the Plan will pay 100% of his or her Covered Expenses. After the family Out-of-Pocket Maximum has been met, the Plan will pay 100% of each eligible family member's Covered Expenses.	
Preventive Care	
Preventive Care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of the office visit.	Plan Pays 100%
Immunizations	Plan Pays 100%

Benefit	Out-of-Area
Mammogram, PAP, and PSA Tests • Routine services	Plan Pays 100%
Physician Services	
PCP Office **Specialist Office**	Plan Pays 80% after Deductible Plan Pays 80% after Deductible
Surgery Performed in the Physician's Office • PCP Office • Specialist Office	Plan Pays 80% after Deductible Plan Pays 80% after Deductible
Allergy Treatment/Injections • PCP Office • Specialist Office	Plan Pays 80% after Deductible Plan Pays 80% after Deductible
Allergy Serum (Medication only dispensed by the Physician in the Office)	Plan Pays 80% after Deductible
Inpatient	
Inpatient Hospital Facility • **Semi-private and Private rooms:** Limited to the In-Network semi-private negotiated rate • **Special Care Units:** Intensive Care Unit (ICU), Critical Care Unit (CCU): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to the ICU/CCU daily room rate	Plan Pays 80% after Deductible
Inpatient Hospital Physician's Visit/Consultation	Plan Pays 80% after Deductible
Inpatient Professional Services: • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after Deductible
Outpatient	
Outpatient Facility Services	Plan Pays 80% after Deductible
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists	Plan Pays 80% after Deductible
Short-Term Rehabilitation Calendar Year Maximum: 180 days • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Rehabilitation **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short-term rehabilitation therapy maximum.	Plan Pays 80% after Deductible
Chiropractic Care • Calendar Year Maximum: 25 days	Plan Pays 80% after Deductible
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private-duty nursing subject to medical necessity) • Calendar Year Maximum: 60 days • 16-hour maximum per day	Plan Pays 80% after Deductible

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

Benefit	Out-of-Area
Lab In: • Physician's Office • Independent Lab • Emergency Room/Urgent Care Facility • Outpatient Facility	Plan Pays 80% after Deductible Plan Pays 80% after Deductible $150 Copay/$75 Copay after Deductible Plan Pays 80% after Deductible
Diagnostic and Advanced Radiological Imaging (ARI) in: • Physician's Office • Independent Lab • Emergency Room/Urgent Care Facility • Outpatient Facility **Note 1:** ARI includes MRI, MRA, CAT Scan, PET Scan, etc. **Note 2:** All lab and X-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit.	Plan Pays 80% after Deductible Not Applicable Plan Pays 100% after Deductible Plan Pays 80% after Deductible
Emergency Care • Emergency Room • Outpatient Professional Services **Urgent Care** • Urgent Care Services • Outpatient Professional Services **Ambulance Services** • If used as Non-Emergency Transportation (e.g., transportation from hospital back home), services generally are not covered. **Note:** Copays are waived if admitted.	You Pay $150 Copay Per Visit Plan Pays 100% after Deductible You Pay $75 Copay Per Visit Plan Pays 100% after Deductible Plan Pays 80% after Deductible
Hospice Care and Bereavement Counseling • Inpatient Hospital and Other Health Care Facilities • Outpatient Services **Note:** Services provided by mental health professionals are covered under mental health benefits.	Plan Pays 80% after Deductible Plan Pays 80% after Deductible
Organ Transplant Coverage Includes all medically appropriate, non-experimental transplants **Inpatient Hospital Facility** • LifeSOURCE Facility **Inpatient Professional Services** • LifeSOURCE Facility Travel Lifetime Maximum to a LifeSOURCE Facility $10,000 Per Transplant (If using an approved LifeSOURCE facility)	Plan Pays 80% after Deductible Plan Pays 80% after Deductible

Benefit	Out-of-Area
Maternity • Initial Visit to Confirm Pregnancy	Plan Pays 80% after Deductible
Global Maternity Fee • All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan Pays 80% after Deductible
Office Visits in Addition to Global Maternity Fee	Covered same as Physician Services Office Visit
Delivery Facility • Inpatient Hospital, Birthing Center	Covered same as Plan's Inpatient Hospital benefit
Abortion – Elective and Non-Elective Procedures	
• Physician's Office	Plan Pays 80% after Deductible
• Inpatient Facility	Plan Pays 80% after Deductible
• Outpatient Facility	Plan Pays 80% after Deductible
• Inpatient Professional Services	Plan Pays 80% after Deductible
• Outpatient Professional Services	Plan Pays 80% after Deductible
Family Planning – Men's Services Office Visits, Lab and Radiology Tests, and Counseling Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
• Physician's Office	Plan Pays 80% after Deductible
• Inpatient Facility	Plan Pays 80% after Deductible
• Outpatient Facility	Plan Pays 80% after Deductible
• Inpatient Professional Services	Plan Pays 80% after Deductible
• Outpatient Professional Services	Plan Pays 80% after Deductible
Family Planning – Women's Services	
• Physician's Office	Plan Pays 100%
• Inpatient Facility	Plan Pays 100%
• Outpatient Facility	Plan Pays 100%
• Inpatient Professional Services	Plan Pays 100%
• Outpatient Professional Services	Plan Pays 100%
Note: Includes coverage for contraceptive devices [i.e., Depo-Provera and Intrauterine Devices (IUDs)] as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office. Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Infertility Services • Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	

Benefit	Out-of-Area
Temporomandibular Joint (TMJ) Services provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Non-Surgical: Unlimited maximum per lifetime • Physician's Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services	Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible
Bariatric Surgery (in accordance with medical necessity requirements) • PCP Office • Specialist Office • Inpatient Facility • Outpatient Facility • Inpatient Professional Services • Outpatient Professional Services Surgeon Charges Lifetime Maximum: $10,000 Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible

Benefit	Out-of-Area
Mental Health and Substance Abuse Disorder Services	
Mental Health/Substance Abuse Disorder Utilization Review, Case Management, and Programs; Inpatient and Outpatient Management • Inpatient Management Only • Inpatient utilization review and case management	
Mental Health or Substance Abuse Disorder • Inpatient • Outpatient – Physician's Office • Outpatient – All Other Services **Note 1:** Calendar Year Maximum: Unlimited • Services are paid at 100% after you reach your Out-of-Pocket Maximum. • Inpatient includes Rehabilitation, Residential Treatment, and Detoxification. • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy. **Note 2:** ABA (Applied Behavioral Analysis) Therapy is covered under Mental Health – Outpatient	Plan Pays 80% after Deductible Plan Pays 80% after Deductible Plan Pays 80% after Deductible

Excluded Services

Indemnity

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

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Prescription Drug Plan

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Your Prescription Drug Benefits

The prescription drug benefit available to you is based on the medical plan in which you are enrolled. Regardless of the benefit design that is applicable to your coverage, you can get up to a 30-day supply at a retail network pharmacy, and a 90-day supply at the mail order pharmacy.

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

Certain drugs may be excluded, or a prior authorization may be necessary in order to receive the prescription or the full quantity your doctor prescribes. In some cases, a generic drug may be substituted for a brand name medication. For a current listing of the categories, including those that require prior authorization you may refer to the Express Scripts website.

A number of clinical programs are offered by Express Scripts to promote appropriate utilization of drug therapy. All of these programs have been implemented to assist in controlling costs and providing coverage that is clinically appropriate and consistent with the Plan's intent. A drug must be approved by the Federal Drug Administration (FDA) to be covered under the Plan. Compound drugs that contain non-FDA approved ingredients are not covered under the Plan.

The programs and coverage criteria are subject to change.

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

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

Express Scripts Member Services

Toll Free: 1-877-765-6543

Website: www.express-scripts.com

Summary of Benefits: Prescription Drugs

Choice Fund with HSA –Metal Trades Council (MTC); Pantex Guards Union (PGU); and Pantex Non-Bargaining

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

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Core – Pantex Guards Union (PGU)

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	None	None
Retail 30-Day Supply		
Generic	$5 Copay	50% Coinsurance after Deductible
Brand	$25 Copay	50% Coinsurance after Deductible
Non-Preferred	$50 Copay	50% Coinsurance after Deductible
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$10 Copay	Not Covered
Brand	$40 Copay	Not Covered
Non-Preferred	$70 Copay	Not Covered

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Select – Pantex Guards Union (PGU)

Prescription Drugs Summary		
You Pay		
	In-Network	**Out-of-Network**
Annual Prescription Drug Deductible	None	None
Retail 30-Day Supply		
Generic	$5 Copay	50% Coinsurance after Deductible
Brand	$15 Copay	50% Coinsurance after Deductible
Non-Preferred	$30 Copay	50% Coinsurance after Deductible
Mail Order – Home Delivery – Up to 90-Day Supply		
Generic	$10 Copay	Not Covered
Brand	$30 Copay	Not Covered
Non-Preferred	$60 Copay	Not Covered

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Core –Metal Trades Council (MTC); and Pantex Non-Bargaining

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

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

PPO Select –Metal Trades Council (MTC); and Pantex Non-Bargaining

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

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

Summary of Benefits: Prescription Drugs

Indemnity

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

1. Pharmacy benefits are through Express Scripts.
2. Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. For a listing of the brand names or categories that currently require prior authorization, contact Express Scripts.
3. Express Scripts may substitute an equivalent drug within certain drug categories due to procurement restrictions in contracts between drug manufacturers and Express Scripts. While the Company prescription plan and its participants may be impacted by these contract limitations, medical safety and outcomes will not be compromised.
4. Certain drugs may be excluded under the Plan for such reasons as clinical cost, not FDA approved, manufacturer availability, quantity limits, or safety reasons, which may change over time. Notice of changes in the exclusion list will be provided to covered members in advance, unless market conditions (such as supply chain shortage) restrict advance notice.
5. **Note:** Infusion therapy drugs are administered under the medical plan.

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

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

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

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

What is covered?

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

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there may be no alternatives to try for coverage. To check whether a medication is excluded, contact Express Scripts.

What is a formulary drug?

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

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

What is a generic drug?

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

What is a brand drug?

A brand drug is protected by a patent, which prevent other companies from manufacturing the drug while the patent is in effect. A preferred brand drug is a drug that is covered under the Plan. Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved by the group of physicians and pharmacists, and have been added to the Express Scripts formulary list for the Plan, based on their proven clinical and cost effectiveness.

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

What is a specialty drug?

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

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

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

What is a compound drug?

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

What is a network retail pharmacy?

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

When should a retail network pharmacy be used?

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

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

What if the retail pharmacy is not in the network?

Prescriptions filled at a nonparticipating retail pharmacy are not covered under the Plan, which means if you fill prescriptions there, you pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's Deductible or Out-of-Pocket Maximums.

When should the home delivery mail pharmacy be used?

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

Features of the home delivery mail pharmacy?

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

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

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

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

Refills can be ordered electronically downloading and using the Express Scripts mobile app, logging on the website, through the mail, or by phone. You may also set prescriptions to renew automatically.

When should the specialty pharmacy, Accredo, be used?

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

How are claims paid?

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

What is a benefit exclusion?

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

What is prior authorization?

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

Coverage Reviews:

Is there an appeal process for a denied claim?

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

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

Information about coverage reviews can also be found on Express Scripts website.

There are *Clinical Coverage Reviews* and *Administrative Coverage Reviews*.

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

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

Initial Coverage Review

How do I request an initial coverage review?

- To request an *Initial Clinical Coverage Review*, *also called Prior Authorization*, your doctor may submit the request electronically. Information about electronic options can be found at express-scripts.com/PA.
- To request an *Initial Administrative Coverage Review*, you may submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

  Complete the form and fax it to 1-877-328-9660 or mail to:

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

How do I request an Urgent Coverage Review?

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

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

Urgent Clinical Appeal Requests:

Phone 1-800-753-2851
Fax 1-877-852-4070

Urgent Administrative Appeal Requests:

Phone 1-800-946-3979
Fax 1-877-328-9660

Level 1 Appeal or Urgent Appeal:

How do I request a Level 1 Appeal or Urgent Appeal after an Initial Coverage Review is denied?

When an Initial Coverage Review has been denied, also referred to as an Adverse Benefit Determination, a request for appeal may be submitted within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for Clinical or Administrative Review Requests:

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

Level 2 Appeal:

How do I request a Level 2 Appeal after a Level 1 Appeal is denied?

When a Level 1 Appeal has been denied, also called an Adverse Benefit Determination, a request for a Level 2 Appeal may be submitted within 90 days from receipt of notice of the Level 1 Appeal Adverse Benefit Determination. To initiate a Level 2 Appeal, the following information must be submitted by mail or fax to the appropriate department for Clinical or Administrative Review Requests:

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

Clinical appeal requests and administrative appeal requests can be mailed to the following:

Clinical Appeal Requests:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
1-877-852-4070

Administrative Appeal Requests:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6588
1-877-328-9660

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Vision Plan

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The Vision Plan

The Vision Plan is a self-funded plan administered by Vision Service Plan (VSP). VSP administers and manages the network of vision service providers. Your Out-of-Pocket costs will be higher if you use an Out-of-Network Provider.

Your Vision Benefits

When you need vision care, you can go to a VSP Network Provider or an Out-of-Network Provider. Network Providers will file your claim with VSP. A list of VSP In-Network Providers is available as noted below:

Website: www.vsp.com
Customer Service: 1-800-877-7195

Mail your claim to VSP at the address below for Out-of-Network Providers:

VSP Member Claims
Attention: Claims Services
PO Box 495933
Cincinnati, OH 45249

Exclusion for Surgery or Disease

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

VSP Vision Features:

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

Summary of Benefits: Basic Vision Plan

Metal Trades Council (MTC); Pantex Guards Union (PGU); and Pantex Non-Bargaining

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

Summary of Benefits: Alternative Vision Plan

Metal Trades Council (MTC) and Pantex Non-Bargaining

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

Summary of Benefits: Buy-Up Vision Plan

Pantex Guards Union (PGU)

Services Covered	In-Network	Out-of-Network
Exam – once every calendar year	Covered in full	Exam – up to $45
Lenses – once every calendar year • Single Vision • Bifocal • Trifocal • Lenticular	Covered in full	Single Vision – up to $ 45 Bifocals – up to $ 65 Trifocals – up to $ 85 Lenticular – up to $ 125
Frames – once every other calendar year	$225 allowance 20% discount for amount exceeding $225 or $125 allowance at Costco Optical	Frames – up to $ 47
Contact Lens – once every calendar year (instead of glasses)	Medically Necessary lenses: covered in full Elective lenses: $225 maximum allowance for contacts and contact lens exam (fitting and evaluation) 15% off contact lens exams	Medically Necessary lenses – up to $ 210
Lens Enhancements – once every calendar year	Standard Progressive, Premium Progressive, Custom Progressive, Photochromic and tinted lenses all covered in full	Progressive lenses – up to $ 65 Photochromic and tinted lenses – $15/$75
Additional Discounts	20% discount on additional prescription glasses and sunglasses at any VSP provider within 12 months of your last exam Laser Vision Correction – average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	Not Available

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Dental Plan

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MetLife Dental Plan – How the Dental Plan Works

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

The Dental Plans:

- Encourage preventive care;
- Promote regular dental care by covering preventive and diagnostic services, such as routine checkups, cleanings, and X-rays;
- Offer protection for more extensive treatment;
- Provide oral surgery and restorative and prosthodontic services; and
- Offer coverage for orthodontia treatment for your covered Children under age 21 in specified plans.

Choosing a Dentist

Participating Dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists who have not contracted with MetLife are referred to as "Non-Participating Dentists."

Although you are free to choose any dentist, your Out-of-Pocket expenses may be less if you choose a Participating Dentist. Therefore, you should always ask your dentist if he or she is a Participating Dentist or verify with MetLife that your dentist is a Participating Dentist before receiving any dental services.

Participating vs. Non-Participating Dentist

Seeing a dentist that participates in MetLife's Preferred Provider Organization (PPO) Network gets you the best discounted rates with no balance billing or paperwork to file. This is the Maximum Plan Allowance (MPA).

You are responsible for charges exceeding the MPA if you go to a Non-Participating Dentist. The MPA charges are based on fees charged in your geographic area. To find a MetLife Participating PPO or Premium Dentist visit www.metlife.com and click on "Find a Dentist" or call 1-800-942-0854.

MetLife Dental Schedule of Benefits

In addition to the Limitations and Exclusions listed in this "Schedule of Benefits" section, the "General Limitations and Exclusions" section also applies.

Types of Dental Services

Preventive and Diagnostic Services are:

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

Limitations and Exclusions:

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

Basic Services are:

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

Limitations and Exclusions:

- Restorative benefits are allowed once per surface in a 12-month period, regardless of the number or combinations of procedures requested or performed
- Payment for root canal treatment includes charges for X-rays and temporary restorations. Root canal treatment is limited to once in a 24-month period by the same dentist or dental office
- Payment for periodontal surgery shall include charges for three months' post-operative care and any surgical re-entry for a three-year period. Root planing, curettage, and osseous surgery are not a benefit for members under 14 years of age
- The replacement of amalgam or composite restorations within 12 months by the same dentist or dental office is not a benefit

The replacement of a stainless-steel crown by the same dentist or dental office within a 24-month period of the initial placement is not a benefit

- Gold foil restorations, porcelain composite, and metal inlays are an optional service
- A sealant is a benefit only on the unrestored, decay-free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars. Sealants are only a benefit to members up to age 16. Only one benefit will be allowed for each tooth within a lifetime

Major Services are:

- Cast Restorations – crowns and on-lays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations
- Prosthodontics – procedures for construction of fixed bridges and partial or complete dentures and repair of fixed bridges
- Complete or Partial Denture Reline – chairside or laboratory procedure to improve the fit of the appliance to the tissue (gums)
- Complete or Partial Denture Rebase – laboratory replacement of the acrylic base of the appliance
- Denture Repairs – services to repair complete or partial dentures

Limitations and Exclusions:

- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration, and any re-cementation by the same dentist within a 12-month period
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not covered
- Procedures for purely cosmetic reasons are not covered
- Porcelain, gold, or veneer crowns for children under 12 years of age are not covered
- Replacement of any fixed bridges, or partial or complete dentures, that the member received in the previous five years is not covered
- Payment for a complete or partial denture shall include charges for any necessary adjustment within a six-month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a three-year period and includes all adjustments required for six months after delivery
- Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference
- Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit
- A posterior bridge where a partial denture is constructed in the same arch is not covered
- Temporary partial dentures are covered only when upper anterior teeth are missing

Orthodontia Services

Note: Orthodontia services must be specifically elected, at a higher premium, unless you are in a class with different union negotiated services as noted in the Summary of Benefits.

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

Limitations and Exclusions:

- The orthodontia benefit's maximum age and maximum benefit is noted in the Summary of Benefits
- MetLife shall make regular payments for orthodontia benefits
- If orthodontia treatment began prior to enrolling in this plan, MetLife will begin benefits with the first payment due to the orthodontist after becoming eligible under this plan
- Benefits end with the next payment due to the dentist after loss of eligibility or immediately if treatment stops
- Benefits are not paid to repair or replace any orthodontia appliance received
- Orthodontia benefits do not pay for extractions or other surgical procedures; however, these additional services may be covered under other benefits of this plan
- The initial payment (initial banding fee) made by MetLife for comprehensive treatment will be 33% of the total fee for treatment subject to your Copayment percentage and lifetime maximum
- Subsequent payments will be issued on a regular basis for continuing active orthodontia treatment. Payments will begin in the month following the appliance placement date and are subject to your Copayment percentage and lifetime maximum

Predetermination of Benefits

Predetermination of benefits is an estimate of the cost of certain dental procedures before they are done. You may have your dentist send MetLife a claim form detailing the projected treatment, and MetLife will give an estimate of the benefits to be paid. This will let you know approximately how much the work will cost and what your share of the costs will be. A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.

Optional Services

In cases where alternate or optional methods of treatment exist, MetLife will pay for the least costly, professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of your coverage. The dentist and you or Eligible Dependent should decide the course of treatment.

If the treatment rendered is other than the covered benefit, the difference between the MetLife allowance and the dentist's fee, up to the approved amount, for the actual treatment rendered is due from you. For example, if your benefit plan allows for amalgams only, even though a metal or porcelain inlay is suggested by your dentist, MetLife will pay for only the cost of the amalgam.

Some facts to remember about your dental plans:

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

General Provisions

- If you need a claim form for services provided by a Non-Participating Dentist, you may contact MetLife. A claim must be filed within 15 months of the date of service.
- If you require emergency dental care, you may seek services from any dentist. Your Out-of-Pocket expenses may be less if you choose a Participating Dentist.
- If you or your covered Eligible Dependent receives an injury requiring dental treatment because of the action or fault of another person, and if MetLife is unaware of other coverage, MetLife may pay benefits but would assume you or your covered Eligible Dependent's rights to recover from the other person. You and your covered Eligible Dependent would be required to help MetLife in making such a recovery.
- This dental plan does not replace any workers' compensation coverage.
- If you or your covered Eligible Dependent has two dental coverages, MetLife will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
  - The program covering the patient as an employee is primary over a program covering the patient as a dependent.
  - Where the patient, who is a Child, is an Eligible Dependent, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a Child who is an Eligible Dependent of legally separated or divorced parents, the coverage of the parent with legal custody or the coverage of the custodial parent's Spouse (i.e., step-parent) will be primary.
  - If there is a court decree stating that one parent has financial responsibility for a Child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.
- After a claim is processed, an Explanation of Benefits (EOB) will be available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial, you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request must be received by MetLife within 180 days of your receipt of the EOB. MetLife will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to you within 30 days after MetLife receives the request for review.
- If you do not agree with the First-Level Review decision, you may refer the request for review to the Professional Relations Advisory Committee of MetLife. This second-level review request must be in writing and received by MetLife within a reasonable time after you receive the First-Level Review decision. Unless unusual circumstances arise, a decision will be sent to you within 30 days after MetLife receives the request for Second-Level Review. If you do not agree with the Second-Level Review decision, you may file civil action in court.

General Limitations and Exclusions

In addition to the limitations and exclusions shown in the Schedule of Benefits section, MetLife does not pay for the following:

- Treatment of injury or illness covered by Workers' Compensation or other Employer's Liability Laws
- Services received without cost from any federal, state, or local agency (This exclusion will not apply if prohibited by law)
- Cosmetic surgery or procedures for purely cosmetic reasons
- Services for congenital (hereditary) or developmental malformations (Such malformations include, but are not limited to, cleft palate or upper- and lower-jaw malformations. This does not exclude those services provided under orthodontia benefits, if covered)
- Treatment to restore tooth structure lost from wear
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth (e.g., equilibration, periodontal splinting, double abutments on bridges)
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues)
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction
- Services by a dentist beyond the scope of his or her license
- Dental services for which the patient incurs no charge
- Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed
- MetLife will apply the Limitations and Exclusions of this benefit plan based upon the member's complete and prior history as reflected in MetLife's records

In the event a member transfers from one dentist to another during the course of treatment, payment by MetLife will be limited to the amount that would have been paid had only one dentist rendered the service.

Extended Dental Care Benefits

Coverage for you or your Eligible Dependent terminates when you or your Eligible Dependent is no longer eligible for benefits as a member of the group. Specific state or federal laws or group policies may allow an extension of benefits for a limited time. MetLife will determine whether any benefits are available and how long the benefits could be extended.

What happens to your benefits when?

For more information about what happens to your dental benefits when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section. For more information about coverage, you and your Eligible Dependents may be eligible to continue in certain cases when coverage would otherwise end, refer to COBRA within the "Administrative Information" section.

MetLife Dental Plan

Pantex Guards Union (PGU) and Pantex Non-Bargaining

Summary of Benefits			
	Basic	**Buy-Up**	**Enhanced**
Annual Benefit Maximum	$1,500 per person	$2,000 per person	
Lifetime Maximum	None		
Annual Deductible	$50 per person		
Preventative and Diagnostic Services*			
Oral Examinations twice every calendar year	Plan pays 100%		
Prophylaxis twice every calendar year (cleanings)	Plan pays 100%		
Full-Mouth X-rays once every three years	Plan pays 100%		
Bitewing X-rays twice every calendar year	Plan pays 100%		
Fluoride twice every calendar year (up to age 19)	Plan pays 100%		
Space Maintainers	Plan pays 100%		
Sealants	Plan pays 80% after Deductible		
Basic Services*			
Emergency Palliative Treatment to temporarily relieve pain	Plan pays 80% after Deductible		Plan pays 90% after Deductible
Minor Restorative Services (fillings, excludes gold) Endodontic Services (root canals) Periodontia Services (to treat gum disease)	Plan pays 80% after Deductible		Plan pays 90% after Deductible
Oral Surgery (complex extractions and certain surgical procedures)	Plan pays 80% after Deductible		Plan pays 90% after Deductible
Adjustments and Repairs (to bridges and dentures)	Plan pays 80% after Deductible		Plan pays 90% after Deductible
Occlusal Guards once per lifetime	Plan pays 80% after Deductible		Plan pays 90% after Deductible
Major Services*			
Crowns	Plan pays 50% after Deductible		Plan pays 80% after Deductible

Bridges	Plan pays 50% after Deductible	Plan pays 80% after Deductible
Partial, full dentures and implants	Plan pays 50% after Deductible	Plan pays 80% after Deductible
Orthodontia Services*		
Orthodontia Services for Child(ren) (up to age 21)	Not covered	Plan pays 50%
Lifetime Orthodontia Maximum	N/A	$1,500 per person

**Plan limits apply to certain services.*

MetLife Dental Plan

Metal Trades Council (MTC)

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

**Plan limits apply to certain services.*

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Employee Assistance Program

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The Employee Assistance Program is a confidential service designed to help you and your family solve personal problems that may affect your health, family life, or job performance.

The Employee Assistance Program:

Services provided by Aetna Resources for Living are available to you, and all your Eligible Dependents, regardless of your other benefit coverage. You receive up to eight face-to-face counseling sessions per issue, per year with licensed network professionals at no cost to you.

Key features are:

- The program can help you and your Eligible Dependents by providing support, consultation, and resources for:
  - Stress
  - Family relationship issues
  - Anger management
  - Substance abuse
  - Helping you balance work and home life
- You have direct access to a full range of web-based tools and resources, self-assessments, and more information on a variety of relevant topics.
- You have unlimited, toll-free telephone access 24 hours a day, seven days a week.
- Counselors are available for appointments during normal business hours, including during evening hours and Saturdays. When you call the Employee Assistance Program, you will be encouraged to make an appointment to meet with a trained counselor in person. If you decide to meet face-to-face, you will be offered an appointment with a program counselor within five days. In an emergency, a counselor will be available to meet with you as soon as possible. Together, you and the counselor will discuss your concerns and decide the appropriate course of action.
- The program ensures complete confidentiality.

Add-on Services

Legal Services

- You receive $^1/_2$ hour free consultation with a Participating Attorney for limited services and topics:
  - General law (excluding employment law)
  - Mediation services
  - Special needs, including emergency matters
  - Document preparation

Financial Services

- You receive 1/2 hour free consultation on new financial counseling topics each year:
  - Budgeting
  - Debt
  - Credit
  - Retirement
  - College funding
  - Financial planning
  - Taxes
  - 25% discount on tax preparation services

Identity Theft Services

- You receive:
  - 1-hour telephonic fraud resolution consultation

Access web-based tools and resources

- You receive easy-to-find information, self-assessments, and more
- Online discounts on brand-name products and services

Care kits related to child or elder care and prenatal care

What happens to your benefits when?

For more information about what happens to your Employee Assistance Program coverage when certain changes or events occur, see "How Changes Affect Your Benefits" in the "About Your Benefits" section.

Cost of Treatment

Any consultation between a program counselor and you or your Eligible Dependents is free of charge.

If you are referred outside the program for treatment, you will be responsible for paying for the treatment. Treatment outside the program may be available under your medical coverage.

Confidentiality

Using the Employee Assistance Program is strictly confidential. The provider will never release any information about you or an Eligible Dependent unless you give your written permission or unless required by law.

How to Contact the Employee Assistance Program

If you or your Eligible Dependents needs help, contact the Employee Assistance Program directly at 1-866-611-2826 or visit online at www.resourcesforliving.com (Username: PANTEX Password: EAP).

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Flexible Spending Accounts

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Flexible Spending Accounts (FSAs)

Flexible Spending Accounts offer a convenient way to pay for health and dependent care expenses on a before-tax basis, reducing your taxable income.

You may refer to the Department of the Treasury Internal Revenue Service (IRS) Publication 502, *Medical and Dental Expenses* (including the Health Coverage Tax Credit), and Publication 503, *Child and Dependent Care Expenses;* your personal financial or tax advisor; or visit the IRS website at www.irs.gov for more tax information.

Flexible Spending Accounts:

Give you choices

You can contribute to the Healthcare Flexible Spending Account, the Dependent Care Flexible Spending Account, or both. Each year, you can contribute from $50 up to the maximum allowed per IRS guidelines to the Healthcare Flexible Spending Account to pay for certain health-related expenses; such as Copays for visits to the doctor and Out-of-Pocket Expenses for prescriptions; other healthcare services for medical, dental, and vision care; and for over-the-counter drug and menstrual care product expenses that have not been otherwise reimbursed. Also, you can contribute from $50 up to the maximum allowed per IRS guidelines to the Dependent Care Flexible Spending Account to pay for day care and elder care expenses for Eligible Dependents.

> **No Transfers Allowed**
>
> Remember, you may not transfer money between Flexible Spending Accounts. Money set aside in your Healthcare Spending Account cannot be used to reimburse dependent care expenses and vice versa.

Offer convenience

Your Flexible Spending Account contributions are automatically deducted from each paycheck and credited to your Flexible Spending Accounts.

Save you money in taxes

The money in your accounts is not subject to federal income taxes, Social Security taxes, or Medicare taxes. And, in most places, state and local taxes also do not apply. This means that many of your routine health and dependent care services will actually cost you less. You will not pay taxes on the amounts you contribute to either account, and your annual taxable income is reduced by the amount of your contribution.

Require careful planning

You need to estimate your expenses for the upcoming year carefully, during the annual benefits Open Enrollment, when deciding how much to contribute to the Flexible Spending Accounts. According to Internal Revenue Service rules, any money left in your account for which a reimbursement claim is not incurred by the deadline (i.e., March 15 of the following year) will be forfeited. In other words, use it or lose it.

What happens to your benefits when?

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

How the Flexible Spending Accounts Work

Follow these steps to put the Flexible Spending Accounts to work for you:

- **Estimate your expenses.**

  Each year, you calculate these expenses for the upcoming year: any Out-of-Pocket medical, dental, vision care, prescription, and over-the-counter drug and menstrual care product expenses and your dependent care expenses. You should estimate carefully because you will forfeit any unused funds.

- **Decide on your annual contribution.**

  You can contribute a whole-dollar amount from $50 up to the maximum allowed per IRS guidelines on a before-tax basis to the Healthcare Flexible Spending Account and from $50 to the maximum allowed per IRS guidelines on a before-tax basis to the Dependent Care Flexible Spending Account. The two accounts are separate, and you may not transfer funds between the two. Once you begin contributing, you may not change or stop your contributions during the year unless you have a Qualifying Life Event as described in the "About Your Benefits" section.

  You can contribute to the Healthcare Flexible Spending Account if you are enrolled in a Non-High Deductible Plan provided by PXD, or a Non-High Deductible medical plan outside of the PXD 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 Healthcare Flexible Spending Account if you are enrolled in the Choice Fund HSA plan or if you are enrolled in another High-Deductible medical plan outside the PXD plan.

  The Dependent Care Flexible Spending Account is only used for dependent care expenses that allow you to work. It is not used for dependents' healthcare expenses. You do not need to be enrolled in a health plan to participate in the Dependent Care Flexible Spending Account. For additional information see Dependent Care Flexible Spending Account later in this section.

  Your contributions are taken from your paycheck before federal and state taxes are deducted, making these amounts tax free.

File a claim

Cigna administers both the Healthcare Flexible Spending Account and the Dependent Care Flexible Spending Account.

You may pay for your eligible expenses and submit a claim for reimbursement or you may use your FSA debit card. Save your receipts, even if you use the debit card.

When you have eligible expenses, you can:

- Submit a receipt, reimbursement request, and any other supporting documentation to the Claims Administrator, Cigna.
- Go to www.myCigna.com for account details, including up-to-date balance information, claim status, claim forms, and answers to general questions. Call Cigna at 1-877-774-9913 to speak with a customer service representative 24/7/365.

Although it is a good idea to submit your claims as you incur expenses during the year, IRS rules allow expenses incurred before March 15 of the following year to be used against the previous year's remaining balance. Those claims must be filed no later than June 30 of that year.

Receive reimbursement

Reimbursements from your accounts are made with before-tax dollars.

Reimbursement forms are available from the Pantex Benefits Office or by accessing the Benefit Plans website.

Should you participate?

Here are some questions you may want to ask yourself before you decide to contribute to a Flexible Spending Account:

- **What do you expect your Out-of-Pocket healthcare expenses will be?**

  Start with your deductibles, and then add any medical, dental, vision care, prescription, or over-the-counter drug and menstrual care product expenses that are not covered, such as copayments, charges above Maximum Reimbursable Charge, or charges above plan maximums.

- **What do you expect your dependent care expenses will be?**

  Consider any times of the year when you do not have these child care expenses, such as vacation periods. Also, if your Child will turn 13 during the year, estimate your expenses only for the portion of the year before your Child's 13th birthday.

Changing your Contribution

You may not change or stop your contributions to the Flexible Spending Accounts during the year unless you have a Qualifying Life Event, such as a birth, marriage, or a job loss by your Spouse. The change in contributions must be consistent with the Qualifying Life Event. For example, with the birth of a Child you can increase your contributions but not decrease them.

See the "About Your Benefits" section for more information on Qualifying Life Events. If you stop contributing to the Flexible Spending Accounts, you can be reimbursed only for eligible health and dependent care expenses incurred before you stopped contributing.

Limit for Highly Compensated Employees

Certain highly compensated employees may be limited by the IRS as to how much they can contribute to the Dependent Care Spending Account each year. You will be notified if this limit applies to you.

Tax Savings

The Healthcare and Dependent Care Spending Accounts are designed for one purpose: to allow you to pay for certain expenses on a before-tax basis. Your taxable income is reduced by the amount you contribute to the accounts.

Your participation in the Flexible Spending Accounts may reduce your Social Security retirement benefits. But the current tax advantages generally offset any reduction in Social Security benefits. Since your Social Security taxes will be calculated after your FSA contributions are subtracted, your Social Security benefits may be slightly lowered.

How much can you save on taxes?

Take the amount you will contribute to the Dependent Care and Healthcare Spending Accounts times your federal tax percentage bracket to determine how much federal taxes you save. You

may also save on Social Security and Medicare taxes, and depending on where you live, state and local taxes.

Account Statements

Go to www.myCigna.com for account details, including up-to-date balance information, claim status, claim forms, and answers to general questions. Call Cigna to speak with a customer service representative 24/7/365.

In addition, each time you receive a reimbursement, the accompanying attached explanation provides a summary of year-to-date activity for you.

Healthcare Flexible Spending Account

Contributions

You can contribute whole-dollar amounts from $50 up to the maximum allowed per IRS guidelines annually to the Healthcare Spending Account. Contributions are deducted from your pay each pay period and credited to your Flexible Spending Account.

Healthcare Expenses

You can use the Healthcare Flexible Spending Account to pay for certain medical, dental, vision care, prescription, and over-the-counter drug and menstrual care product expenses for you and your Eligible Dependents that have not been otherwise reimbursed.

The term "Eligible Dependents" is defined in the Glossary.

You and your Eligible Dependents do not have to be covered under the Company's medical, dental, or vision plans to participate in the Healthcare Spending Account. In general, you may be reimbursed for any healthcare expense that is not paid for by an insurance plan and is considered a deductible medical expense by the Internal Revenue Service.

> **Refer to IRS Publication 502 for more information on eligible medical care expenses. To order a copy, call the Internal Revenue Service toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.**

Note: IRS Publication 502 is intended to help taxpayers determine what medical expenses can be deducted on their tax return, not what is reimbursable under a Healthcare Spending Account. Some of the statements in IRS Publication 502 are not applicable when determining whether that same expense is reimbursable from your Healthcare Spending Account. Not all expenses that are deductible are reimbursable under the Healthcare Spending Account and vice versa.

Expenses Not Eligible

Examples of healthcare expenses that are ineligible for reimbursement through the account include:

- Healthcare insurance premiums
- Expenses incurred before your date of participation
- Expenses reimbursed or reimbursable through any other policy, plan, or program
- Expenses claimed as a deduction or credit on your federal income tax return
- Elective cosmetic surgery
- Orthodontia for cosmetic purposes
- Teeth-whitening procedures
- Marriage or family counseling fees
- Household and domestic help, even if recommended by a doctor
- Custodial care in an institution
- Funeral and burial expenses
- Illegal operations or treatments
- Weight-loss programs, unless prescribed by a doctor to treat an existing disease/medical condition
- Maternity clothes, diaper services, etc.
- Vitamins or food supplements taken for general health purposes
- Cosmetics, toiletries, etc.
- Hair transplant or removal
- Transportation expenses to and from work, despite a physical handicap
- Expenses merely beneficial to health, such as vacations or fitness programs, even if recommended by a doctor
- Any expenses incurred after you stop making contributions

Continuation of Coverage

You may be eligible to continue your Healthcare Spending Account participation in certain cases when your participation would otherwise end. You may not, however, continue your participation in the Dependent Care Spending Account. Refer to COBRA within the “Administrative Information” section.

Dependent Care Flexible Spending Account

Contributions

You may contribute to the Dependent Care Flexible Spending Account if you have Eligible Dependent care expenses (that is, you incur expenses to enable you to work). If you are married, you may contribute to this account only if your Spouse is:

- Gainfully employed outside the home
- Actively searching for a job
- Enrolled as a full-time student at least 5 months of the year
- Mentally or physically disabled and unable to provide care for himself or herself

If your Spouse's employment ends during the year, you should contact your Company's benefit office immediately because you may no longer be eligible to participate in this account.

You can contribute in whole dollars from $50 up to the maximum allowed per IRS guidelines annually in before-tax dollars to your Dependent Care Flexible Spending Account. In some cases, however, the IRS limits the amount you can contribute.

Eligible Dependents

You may use the Dependent Care Flexible Spending Account to pay for the care of your Eligible Dependents so you, or if you are married, you and your Spouse can work. Eligible Dependents include:

- Your Children under age 13
- Your Spouse, if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year
- A disabled dependent of any age (including parents) if he or she is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than one-half of the year

An Eligible Dependent is someone you can claim as a dependent on your federal income tax return. A modified definition of dependent applies when determining whether a person who is incapable of self-care (other than a Spouse) is a tax dependent. The married dependent limitations and gross income limitation do not apply.

If you are divorced or legally separated and have custody of your eligible Child, you may use the Dependent Care Flexible Spending Account even though you have agreed to let your Spouse claim the Child as a dependent for tax purposes. If you have joint custody, you may also use the Dependent Care Flexible Spending Account provided you have custody of your Child for a longer period during the year than your Spouse.

Eligible Expenses

Expenses eligible for reimbursement are those incurred to enable you to work and include:

- Services provided in your home by a babysitter or companion, including wages and related taxes
- Services provided by a dependent care center that meets local regulations, cares for more than six non-residents, and receives a fee for such services, whether or not for profit
- Services provided outside your home, such as day camp, preschool tuition, or other outside dependent/child care services, such as before- and after-school programs, but only if the care is for a dependent under age 13 or other Eligible Dependent who regularly spends at least eight hours a day in your home

Generally, eligible child care costs include only those for the actual care of your Child, not costs for education, supplies, or meals, unless those costs cannot be separated.

Expenses Not Eligible

Expenses that are not eligible for reimbursement through the Dependent Care Spending Account include:

- Dependent care provided by your Child (or stepchild) who is under age 19 at the end of the taxable year or by another dependent whom you can claim as an exemption
- Dependent care obtained for non-work-related reasons such as babysitting after your working hours
- Dependent care provided while you are away from work because of illness or leave of absence for more than two weeks
- Dependent care that could be provided by your employed Spouse whose work hours differ from yours
- Expenses for overnight camp
- Dependent care expenses incurred if your Spouse does not work, unless your Spouse is actively seeking employment, a full-time student, or disabled
- Any expenses you claim for the dependent care tax credit on your federal income tax return
- Expenses paid by another organization or provided without cost
- Transportation to or from the dependent care location
- Care provided in a group care center that does not meet state and local laws
- Agency finder fees
- Charges for referral to dependent care providers
- Costs for after-school educational programs
- Costs for clothing, entertainment, or food
- Educational expenses (such as those for private school) for kindergarten or higher
- Expenses incurred before you began contributing to the Account or after you stop contributing

Dependent Care Flexible Spending Account vs. the Federal Tax Credit

Under the current tax law, you can save taxes on dependent care expenses by either claiming a tax credit on your federal income tax return or by participating in the Dependent Care Spending Account. Both are intended to offer you tax savings. The best method for you depends on your income, the number of Eligible Dependents you have, and other factors. However, for most people, using the Dependent Care Spending Account provides a greater tax advantage.

You may use both approaches, but you may not "double deduct" the same expense. In addition, the expenses you apply toward the tax credit will be reduced dollar for dollar by the amount of expenses reimbursed from your account.

You should consult a personal financial or tax advisor to help you decide whether the tax credit or the Dependent Care Flexible Spending Account is more favorable for you.

> **Refer to IRS Publication 503 for a discussion of the tax credit. To order a copy, call the IRS toll-free at 1-800-829-3676 or visit the IRS website at www.irs.gov.**

Filing Claims

When you have an Eligible Dependent care expense, you must pay the provider and then submit a Flexible Spending Account Reimbursement Request Form, along with a bill or receipt, to the Claims Administrator at the address on the bottom of the form. Be sure to include the dependent care provider's Social Security or tax identification number on the form. The annual deadline for filing prior year claims is June 30. You will also have to provide the caregiver's name, address, and taxpayer identification number (or Social Security number) on IRS Form 2441 when you file your federal income tax return. If you cannot supply this information, you should not use the Dependent Care Flexible Spending Account.

> **To obtain IRS Form 2441, call the IRS at 1-800-829-3676 or visit the IRS website at www.irs.gov.**

You will be reimbursed for the lesser of your current account balance or the amount of the claim. If you submit a claim for an amount that exceeds your account balance, you will be reimbursed for the remainder of the claim after you have made sufficient additional contributions for that year to cover the expenses.

Payment of eligible expenses incurred, received, and processed will be made weekly.

Reimbursement forms are available from the Pantex Benefits Office or by accessing the Benefit Plans website.

Remaining Funds

Estimate your Dependent Care Flexible Spending Account contributions carefully. You may continue to file claims for expenses incurred during the plan year until June 30 of the following year. According to IRS rules, you must "use up" amounts deducted from your pay by incurring and filing claims for eligible expenses. Otherwise, you lose the money you have left in your account.

Any forfeited amounts will be used to offset the Plan's administrative expenses.

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Disability Coverage

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Your Disability benefits are designed to provide continuing income if you are a current Employee and you are unable to work due to illness, injury, or pregnancy.

Disability Benefits

- The Company provides some coverage under the Short-Term and the Long-Term Disability plans. The benefit amount for bargaining unit versus non-bargaining Employees varies and is explained under the "Benefit Amount" section.
- Your disability benefits may be reduced by other income benefits, such as Workers' Compensation and Social Security payments that you receive while disabled.

What happens to your benefits when ...?

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

Short-Term Disability Plan

The Short-Term Disability (STD) plan may continue to provide a percentage of your Pay for up to six months of your medically-approved disability. It is your obligation to provide the documentation required to meet the eligibility criteria for STD benefits. This includes certification of your disability by a licensed practicing physician. Payment under the Company's STD plan will not be made until the determination of medical necessity has been received and approved.

Unless Medically Necessary, elective or cosmetic procedures are not covered under the STD plan.

Claims covered by Workers' Compensation run concurrently with any applicable STD benefits. STD benefits may also be reduced by other disability income benefits you are eligible to receive from other sources, including but not limited to, the Energy Employees Occupational Illness Compensation Program Act, Social Security disability, or retirement benefits, or other sources of income.

STD benefits may vary depending upon your employee classification.

Claiming Short-Term Disability Benefits

If you are unable to work because of a qualifying absence, you must furnish periodic medical evidence of your inability to work as requested by the Company or its Third-Party Administrator in order to receive benefits under the STD plan. You may not file a claim for benefits if you are no longer a Company Employee, and only current Company Employees are eligible for these benefits.

The Company reserves the right to confirm your disability with a physician and/or require a written statement from your treating physician at any time during your absence. Upon return to work, the Company requires a physician's statement indicating that you are released to return to work.

In addition, during your disability you may be required to undergo periodic evaluations by your Company's Occupational Health Services Department in order for the Company to determine if you are able to return to light duty work. If the Company's Occupational Health Services Department and your physician determine that you are able to return to light duty work, and you do not return to work, benefits for STD will end.

When Short-Term Disability Benefits End

Benefits for any absence will end when you:

- Return to work for a full shift
- Do not provide requested satisfactory evidence of your illness or injury
- Do not return to work for light duty if you are able
- Have received the maximum number of benefit payments
- Have your employment terminated by the Company for cause

Benefit Amount

If you are unable to work due to illness, injury, or pregnancy, the STD plan may continue to pay a percentage of your Pay for up to a total of 26 weeks (1,040 cumulative hours) as long as you apply for the benefit, provide any required documentation, and are approved under the provisions of the Plan.

"Pay" is defined in the Glossary.

The benefit amount and period of benefits you receive may depend on your length of service and employee classification.

Non-Bargaining

- If you have between one and six months of Company Service, you are eligible to receive up to one month's Pay for each completed month of service based on the percentage levels listed below.
- You must meet a benefit waiting period of seven consecutive calendar days before STD benefits begin. You may use paid personal leave, paid time off, holidays or unpaid time to meet the benefit waiting period. The waiting period or any remaining portion thereof may be waived if you are hospitalized. For STD purposes, hospitalization is defined as an inpatient admission of 24 or more hours. A visit to the emergency room which lasts 24 or more hours with no inpatient admission does not waive the waiting period requirement.

For Pantex non-bargaining Employees, your sick leave bank may not be used to meet the STD benefit waiting period. Pantex non-bargaining Employees who are approved for STD may use available sick leave hours to receive 100% of their Pay while disabled from working until the Employee's sick leave bank is exhausted. Sick leave hours will run concurrently with STD benefits. If the Employee exhausts sick leave benefits and remains eligible for STD, any remaining STD benefits would be paid based upon the tiered scheduled below.

- If you have six months or more of Company Service, you are eligible to receive Pay for approved claims as follows after meeting the applicable benefit waiting period:
  - 100% of Pay for weeks one through six
  - 80% of Pay for weeks seven through twelve
  - 70% of Pay for weeks thirteen through twenty-six

Note: For non-bargaining Employees, holiday time may not be entered during an approved STD absence.

- Periods of disability are treated as separate periods if they are:
  - Due to unrelated causes and are separated by your return to active work for at least one complete shift
  - Due to the same or related condition and are separated by a return to active work of at least 520 work hours or three calendar months, whichever is longer

Note: For eligible Pantex non-bargaining Employees, available sick leave will be paid at 100% of Pay for weeks one through twenty-six until the sick leave bank is exhausted.

Metal Trades Council (MTC)

- You are eligible upon hire for STD benefits based on the percentage levels listed below.
- You must meet a benefit waiting period of 40 consecutive hours before STD begins. You must use sick leave to meet the benefit waiting period. If you do not have sufficient sick leave hours to meet the waiting period requirement, accrued Time Off with Pay (TOWP) may be used. The waiting period or any remaining portion thereof may be waived if you are hospitalized. For STD purposes, hospitalization is defined as being held overnight in the hospital. A visit to the emergency room which lasts 24 or more hours with no inpatient admission does not waive the waiting period requirement.
- You are eligible to receive Pay for approved claims as follows after meeting the applicable benefit waiting period:
  - 100% of Pay for weeks one through six
  - 80% of Pay for weeks seven through twelve
  - 70% of Pay for weeks thirteen through twenty-six
- Periods of disability are treated as separate periods if they are due to a related or unrelated cause and are separated by a return to work for a continuous period of at least 120 hours, excluding overtime, without any absence (excludes holiday).

Note: For eligible MTC Employees, available sick leave will be paid at 100% of Pay for weeks one through twenty-six until all sick leave hours are exhausted.

Pantex Guards Union (PGU)

- You must meet a benefit waiting period of three full or partial consecutive workdays unless you are hospitalized, have surgery or have a medical condition related to 10 CFR 712 (Human Reliability Program) or 10 CFR 1046 (Medical, Physical Readiness, Training, and Access Authorization Standards for Protective Force Personnel). Hospitalization is defined as inpatient hospital admission.
- You are eligible to receive Pay (not to exceed 12 hours per day) for approved claims as follows:
  - 100% of Pay for weeks one through six
  - 80% of Pay for weeks seven through twelve
  - 70% of Pay for weeks thirteen through twenty-six
- Periods of disability are treated as separate periods if they are due to a related or unrelated cause and are separated by a return to work for a continuous period of at least 30 scheduled work days.

Note: For eligible PGU Employees, available sick leave will be paid at 100% of Pay for weeks one through twenty-six until the sick leave accrual is exhausted.

Long-Term Disability Plan

Your Long-Term Disability (LTD) benefits are designed to provide continuing income if you have an illness, injury or pregnancy. You become eligible to apply for benefits after you have been Totally Disabled (as defined in the Glossary) for six months, 26 weeks, or 1,040 cumulative hours. LTD benefits pick up where STD benefits leave off, provided you have at least six months prior service with the Company at the beginning date of your Total Disability. It is your obligation to provide required documentation of your disability.

Employees with sick leave banks in excess of 26 weeks shall be allowed to exhaust all Sick Leave hours before commencing LTD benefits.

Determining Your Long-Term Disability Benefit

You may not file a claim for benefits if you are no longer a Company Employee, and only current Company Employees are eligible for these benefits.

To calculate the amount you are eligible to receive under the LTD plan, follow these steps:

1. Multiply your monthly Pay by the appropriate percentage of coverage (description of benefit percentage is listed under "Benefit Amount") to determine your maximum monthly benefit.
2. Subtract other income you are eligible to receive to find your adjusted monthly benefit from the Plan. Continue to Step Three only if you are eligible to receive family Social Security.
3. If the resulting total of all income benefits you are eligible to receive is more than 75% of your monthly Pay, or 45% if you did not elect the additional 30% LTD Buy-Up benefit that was available to you, your monthly LTD benefit will be reduced to bring your total disability income to 75% of your monthly Pay (or 45% if you did not elect the additional 30% LTD Buy-Up benefit).

Example:

Assume you are a Non-Bargaining Employee earning $3,000 a month and your benefit level is 60% (30% Company + 30% Buy-Up).	
Monthly Pay	$3,000
LTD benefit percentage	x 60%
Maximum monthly LTD benefit	$1,800
Assume you are eligible for primary Social Security of $800 a month.	
Maximum monthly LTD benefit	$1,800
Primary Social Security	-$800
Adjusted monthly LTD benefit	$1,000
Assume you are eligible for family Social Security of $500 a month.	
Assume earnings of $3,000 per month	$3,000
75% disability benefit	x 75%
	$2,250
Primary Social Security	-$800
Family Social Security	-$500
Total family disability income	$950

Social Security and Long-Term Disability Benefits

You are required to apply for Social Security and any other income you may be eligible to receive as a result of your disability within the first twelve months of disability. If your initial application for Social Security is denied, you are required to pursue the entire Social Security benefits appeals process. If you fail to complete the appeals process, your LTD benefit will be reduced by the estimated Social Security benefit that might have been available to you.

If…	Then…
You later complete the Social Security appeals process and are denied benefits	Your LTD benefits will be retroactively reinstated and you will receive a "catch-up" payment.
You receive a cost-of-living increase to your Social Security disability income after your LTD benefit has been calculated	Your LTD benefits will not change.
Your disability makes you eligible to receive family Social Security benefits	Your total disability income from all sources may not exceed 75% of your monthly pay, or 45% if you did not elect the additional 30% Buy-Up benefit when it was available to you.

Important Information Regarding Medicare, Social Security, and Long-Term Disability

You are responsible for communicating with the Social Security Office and understanding how Medicare eligibility and enrollment fit your personal situation. It is your obligation to enroll yourself or your Eligible Dependent(s) in Medicare in a timely fashion so your out-of-pocket expenses are minimized. The Company's medical plan vendor will coordinate claim payments as though Medicare is in effect, even if you are not enrolled in Medicare.

Contact Social Security or Medicare to receive Social Security Disability Insurance and answer Medicare questions.

Taking a Job While Disabled

If you return to work at the Company on a reduced-hour basis, you may be eligible to continue receiving up to 50% of your LTD benefit level.

If you participate in an Approved Rehabilitative Employment Program outside the Company, approved by both the Company and the Third-Party Administrator, you may continue to receive part of your LTD income for up to 12 months. Your monthly LTD benefits may be reduced by any money received from your rehabilitative earnings. If you want to participate in an Approved Rehabilitative Employment Program, it is your responsibility to apply for any such approved program.

"Approved Rehabilitative Employment Program" is defined in the Glossary.

Exclusions

LTD benefits are not payable for disabilities:

- Occurring during the first 12 months that your plan coverage is in effect if caused by any condition for which you received treatment during the three-month period before your plan coverage became effective
- If you are not under the care of a licensed practicing physician
- Due to an intentional self-inflicted injury
- Resulting from your commission of a felony
- Due to war, declared or undeclared
- Reported after termination of your active employment

Claiming Long-Term Disability Benefits

Within 90 days after your STD begins, the Company's Third-Party Administrator will mail applicable forms to your home address to be completed by you and your treating physician. If forms are not received, contact the Pantex Benefits Office.

Duration of Benefits

The LTD plan continues a portion of your Pay after you have been determined disabled for six months (or 1,040 cumulative work hours). As long as you continue to be disabled under plan provisions, benefits will be payable in accordance with the following schedule:

Non-Bargaining; MTC; and PGU

Age When Disability Begins	Maximum Benefit Period
62 or under	Until 65th birthday or 42 months, if later
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and above	12 months

During the time you are receiving LTD benefits, you must furnish periodic medical evidence of your illness or injury if requested by the Company or the Company's Third-Party Administrator in order to remain eligible to receive benefits.

Pantex Site-Specific Information

- Absent a substantiated need for a reasonable accommodation, non-bargaining Pantex Employees (excluding PGU and MTC) are ordinarily terminated from the payroll when beginning LTD. Employees may request to return to work after receiving LTD benefits and such requests will be considered on a case-by-case basis.
- Pantex Employees (excluding PGU and MTC) can no longer participate in the Company-sponsored medical, dental, or vision plans provided to Employees once they have entered LTD.
- PGU Employees may choose to terminate when reaching LTD status or remain on payroll in a leave of absence status for 24 months.
- MTC Employees may choose to terminate when reaching LTD status or remain on payroll on a leave of absence status for 18 months.
- If the Employee elects to retire while transitioning to LTD, LTD benefits and pension benefits will run concurrently. LTD benefits will be reduced by any Social Security disability or Social Security retirement benefits you receive.
- If the Employee chooses to remain on payroll in a leave of absence status, the employee will continue to accrue service for benefits (excluding Pension) and may continue Company-sponsored medical, dental, or vision at active Employee premium rates.

Benefit Amount

Non-Bargaining

- Your monthly LTD plan base benefit equals 30% of your monthly basic straight time Pay, up to a maximum monthly benefit of $5,000.
- If you elected to purchase the LTD Buy-Up plan, then you are eligible for an additional 30% of your monthly basic straight time Pay, up to a maximum monthly benefit of $8,000.
- The LTD plan is reduced by income benefits you are eligible to receive from other sources, as described under “Reduction of Benefits.”

MTC

- Your monthly LTD plan base benefit equals 35% of your monthly basic straight time Pay, up to a maximum monthly benefit of $5,000.
- If you elected to purchase the LTD Buy-Up plan, then you are eligible for an additional 30% of your monthly basic straight time Pay, up to a maximum monthly benefit of $8,000.
- The LTD plan is reduced by income benefits you are eligible to receive from other sources, as described under “Reduction of Benefits.”

PGU

- Your LTD plan base benefit equals 65% of your monthly basic straight time Pay, up to a maximum monthly benefit of $6,000.
- The LTD plan is reduced by income benefits you are eligible to receive from other sources, as described under “Reduction of Benefits.”

The LTD Administrator will instruct you on how to apply for Social Security benefits.

Reduction of Benefits

Your LTD benefits are reduced by other sources of income that are payable to you because of your total disability. Income that may reduce your LTD benefits includes, but not limited to:

- Workers' Compensation benefits or benefits provided under a similar law, state disability benefits, and other statutory benefits for disability, retirement, or unemployment
- Benefits provided through Company benefit plans
- Any Social Security benefits for which you are eligible, including any benefit received by a dependent on your behalf because of your entitlement (refer to the Social Security and "Long-Term Disability Benefits")

If any of these benefits are payable as a lump sum, your LTD benefit will be calculated as if these benefits are paid monthly. The insurance company may have the right to recover advanced benefits by direct payment or by offsetting against future LTD payments.

Your LTD benefits will not be reduced by any private disability coverage that you have purchased.

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Life and Accident Plans

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Life and Accident Coverage

Life and Accident benefits are designed to provide Beneficiary(ies) some financial security when a life altering event occurs.

- You must be actively at work on the date any Life Insurance coverage would be effective; otherwise, your coverage will be effective on the day you actively return to work.
- If your annual Pay is not an even multiple of $1,000, then Life Insurance coverage may be rounded up to next higher $1,000.
- If you continue working after age 65, your Basic Life and Accidental Death and Dismemberment Insurance coverages will not reduce.

Basic Life

The Company provides a certain amount of Life Insurance to eligible Employees, which is based on your Employee work classification, as outlined below. Certain employee classifications require enrollment and payment of applicable premiums. A summary of the Basic Life Insurance Plan is also outlined below. The plan document that governs the insurance plan coverage provides details of the insurance. The benefit amount the Company provides is noted, as is any applicable retiree coverage.

If you are a Pantex non-bargaining Employee effective 1/1/2015; or
MTC Employee actively at work on or after 3/1/2016, then

- Your Basic Life Insurance coverage pays a benefit of one times your Pay, up to a maximum of $1,000,000.
- You may elect a flat benefit of $50,000 in order to avoid imputed income.
- The Company pays the cost of the coverage. No additional benefits are available upon retirement.
- Upon termination of employment, coverage is portable and convertible.

If you are a PGU Employee your Basic Life Insurance coverage is:

Basic Annual Earnings	Basic Life Insurance
$20,000 and under	$20,000
$20,001 but less than $25,001	$25,000
$25,001 but less than $30,001	$30,000
$30,001 but less than $40,001	$40,000
$40,001 or over	$50,000

- The Company pays for the cost of coverage. No additional benefits are available upon retirement.
- Upon termination of employment, coverage is portable and convertible.

Basic Life Benefit During Active Service

- You must be actively at work on the date any Basic Life Insurance coverage would be effective; otherwise, your coverage will be effective on the day you actively return to work.
- If you continue working after age 65, your Basic Life Insurance coverage will not reduce.
- When your Pay increases your Basic Life Insurance coverage amount will automatically increase. If your Pay decreases, your Basic Life Insurance coverage amount will not decrease

unless you request in writing to be insured for the lower amount. There is one important exception to this "no change" rule. If the decrease is part of a general reduction in Pay or hours affecting all Employees at your site, department, or other identifiable group, your Basic Life Insurance will be reduced if your new Pay rate puts you in a lower coverage level. Any change will be effective immediately.

- If you are on leave of absence, Long-Term Disability, or strike at the time a Pay change is effective, any increase or reduction in Basic Life Insurance will take place upon your return to work.

Basic Life Benefit During Long-Term Disability

All Employees except MTC and Pantex non-bargaining:

- You become Totally Disabled during active service and before age 63, your Basic Life Insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled, or until you reach age 65, whichever is earlier. If you become Totally Disabled on or after age 63, your Basic Life Insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled for two years after your Total Disability began, but not beyond age 70.
- At age 65 or at the expiration of the two-year period, if later, you may be eligible to continue a portion of your Basic Life Insurance amount. You may contact the Pantex Benefits Office to obtain a form showing your Basic Life coverage amount for MetLife to see if you may utilize a portability or conversion of coverage feature to obtain an individual policy.

Note: MTC and Pantex non-bargaining Employees coverage may be convertible to an individual policy.

Basic Accidental Death & Dismemberment (AD&D)

The Company provides Basic AD&D Insurance to eligible Employees, which is based on your Employee classification, as outlined below. This insurance provides benefits only in the event of an accident. The Company pays the premium.

- You must be participating in Basic Life Insurance in order to be eligible for AD&D.
- Under Basic AD&D coverage, you may be eligible for a benefit payment if you should lose eye sight, speech, hearing, a limb, or become paralyzed as a direct result of an accident.
- Benefits are payable to your Beneficiary in the event of your accidental death.
- If you should die as a result of and within 12 months of the date of an accident, the full amount of your coverage is paid to your Beneficiary in a lump sum.
- Your Beneficiary is the same as designated under your Basic Life benefit.
- Dismemberment benefits are paid to the Employee.
- Benefits terminate upon retirement or termination.
- Coverage is portable, but is not convertible.

If you are a non-bargaining Employee, or a MTC Employee actively at work on or after 3/1/2016, then:

- Your AD&D coverage pays a benefit of one times your Pay up to a maximum of $1,000,000.
- The Company pays for the coverage.
- Upon termination of employment, coverage is portable. No additional benefits are available upon retirement.
- Imputed income is not applicable to AD&D coverage.

If you are a PGU Employee your basic AD&D coverage is:

Basic Annual Earnings	Basic AD&D
$20,000 and under	$20,000
$20,001 but less than $25,001	$25,000
$25,001 but less than $30,001	$30,000
$30,001 but less than $40,001	$40,000
$40,001 or over	$50,000

- The Company pays for the coverage.
- Upon termination of employment, coverage is portable. No additional benefits are available upon retirement.
- Imputed income is not applicable to AD&D Coverage.

AD&D During Long-Term Disability

All Employees except MTC and Pantex non-bargaining:

- You become Totally Disabled during active service and before age 63, your AD&D insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled, or until you reach age 65, whichever is earlier. If you become Totally Disabled on or after age 63, your AD&D Insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled for two years after your Total Disability began, but not beyond age 70.

- At age 65, or at the expiration of the two-year period, if later, you may be eligible to continue a portion of your insurance amount. You may contact the Pantex Benefits Office to obtain a form showing your AD&D Coverage amount for MetLife to see if you may utilize a portability or conversion of coverage feature to obtain an individual policy.

Note: MTC and Pantex non-bargaining Employees coverage may be portable to an individual policy.

Basic AD&D – Travel Assistance and Identity Theft Services

- As a Company Employee, and participant in MetLife's AD&D Coverage, you have limited benefits to Travel Assistance and Identity Theft solution services administered by Assistance USA, Inc. (AXA). This is a separate and additional option from the Company-provided Business Travel Accident Insurance discussed later in this section to all Employees.
- While traveling internationally or domestically, Travel Assistance offers you and your dependents medical, travel, legal, financial, and concierge services, 24 hours a day, 365 days a year. You can receive assistance in obtaining the help you need through pre-qualified network providers worldwide.

Services include Travel and Financial Services, Medical Assistance Services, Concierge Services, Mobile Assist Service, and Identity Theft Solutions.

Contact Information:

- Call toll free at 1-800-454-3679 or US collect 1-312-935-3783
- To register, visit: https://www.mytripcompanion.us/?utm_source=certificate&utm_medium=Principal-US

  (Access Code: US1020)

Note: These are services that assist you with a travel or theft situation. It is not insurance. It does not provide reimbursement of expenses for financial loss.

Supplemental Insurance

Group Universal Life Insurance (GUL) and Voluntary Accidental Death and Dismemberment (VAD&D)

- Offers the opportunity for added protection through supplemental, Spouse, and dependent Group Universal Life coverage.
- If you enroll in the GUL Insurance coverage you will be allowed to take advantage of a tax-deferred savings feature.
- In addition to GUL Insurance, Voluntary Accidental Death and Dismemberment (VAD&D) is available and you are responsible for the cost. All active full-time non-bargaining Employees are eligible to elect the VAD&D. The VAD&D is in addition to the Basic AD&D that is provided by the Company.
- You must be actively at work on the date your coverage would be effective; otherwise, your coverage will be effective on the day you actively return to work.
- VAD&D benefits are paid in addition to any other Life and Accident Insurance benefits you are eligible to receive.
- Additional benefits for will preparation, living will, and power of attorney may be available through your GUL coverage. Contact MetLife at 1-800-756-0124 for additional information.

As an active Employee:

- You may purchase GUL Insurance coverage from one to ten times your Pay rounded to the next higher $10,000 up to $1,000,000 to provide greater security for your Beneficiary in case of your death from any cause.
- You may purchase GUL Insurance in amounts from $10,000 to $100,000 in $10,000 increments for your Spouse who is age 20 to 85.
- You may purchase GUL in the amount of $5,000 or $10,000 for your dependent Child(ren) from 15 days old up to age 19 years (up to age 24 years if a full-time student).
- You may purchase VAD&D Insurance for your Spouse or Child(ren). For VAD&D a Child is defined as your maternal Child, adopted Child (including a Child from the date of placement with adopting parents until the legal adoption), or stepchild; and who in each case is under age 26, unmarried, and financially supported by you.
- You may purchase VAD&D Insurance coverage from one to five times your Pay rounded to the next higher $1,000 up to a maximum of the lesser of five times Pay, or $500,000.
- If you elect VAD&D Family Coverage the Spouse and Dependent benefits are:
  - Spouse Only – an amount equal to 50% of your VAD&D coverage. The maximum Spouse coverage is $250,000.
  - Spouse and Child(ren) – an amount equal to 40% for your Spouse only and 10% for each Child of your VAD&D Coverage.
  - Child(ren) Only – an amount equal to 15% of your VAD&D for each Child. The maximum Child coverage is $75,000.
- For the purpose of determining who may become covered for insurance, the term does include any person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States including the National Guard; or is insured under the group policy as an Employee.

- If your VAD&D Spouse or Child sustains more than one covered loss due to an accidental injury, the amount paid, on behalf of any such injured person, will not exceed the full amount.
    - VAD&D Coverage ends upon termination of employment. VAD&D Coverage is portable.
    - If you cease active work due to injury or sickness for more than six months, your VAD&D Coverage will end.
    - Your VAD&D Beneficiary will be the same as under your Basic Life Coverage. If your Spouse or Child should die as result of an accidental injury and within twelve months of the date of an accident, the full amount of coverage will be paid to you.
    - If you or your Spouse die as the result of an accidental injury, contact MetLife to determine if you are eligible to receive other Spouse or Child benefits such as a Child Care Benefit or Child Education Benefit.
    - If you die as the result of an accidental injury, your Spouse may be eligible for a Spouse Education Benefit.
    - A Hospital Confinement Benefit may be available if you or a Dependent are confined to the hospital as a direct result of an accidental injury.

GUL Evidence of Insurability – You may be required to answer health questions for the insurance underwriters and wait for approval of coverage. Evidence of Insurability is required for you if:

- You are enrolling for coverage after 30 days of becoming eligible.
- You are requesting more than the lesser of two times Pay or $300,000 in coverage.
- You are requesting an increase in coverage (for current participants).

GUL When Coverage Ends – Eligible Dependent coverage ends at the earliest of:

- The termination of the employer's GUL Policy due to lapse, surrender, or maturity.
- The date a written request to terminate the coverage is received.
- The date the Spouse or each insured Child ceases to meet any of the eligibility requirements.
- The date the Spouse reaches age 100.
- The date of the insured employee's death.
- The date the Group Universal Life Death Benefit becomes a Paid-Up Death Benefit.

GUL – During Disability

If you become Totally Disabled during active service and before age 60, your GUL Insurance will continue at the level in effect at the time your Total Disability began, for as long as you remain Totally Disabled, or until you reach age 60.

The disability must have continued without interruption for at least nine months.

The coverage must be in force for one year to be eligible for this provision.

For Employees and any dependents enrolled in GUL, coverage will continue on a direct bill basis.

GUL – During Retirement

Supplemental Group Universal Life

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

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

Basic AD&D and VAD&D – Dismemberment Benefits

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

The Plan pays at 25% for the loss of:

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

The Plan pays at 50% for the loss of:

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

The Plan pays at 75% for the loss of:

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

The Plan pays at 100% for the loss of:

- Any combination of hand, foot, or sight in one eye
- Speech and loss of hearing
- Brain Damage
- Paralysis of both arms and both legs

Coma:

- 1% monthly beginning on the 7th day of the Coma for a duration of the Coma to a maximum of 60 months.

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

"Loss" is defined in the glossary.

Workplace Felonious Assault Benefit – If you are injured or die as the result of an accidental injury caused by a felonious assault by another person and committed at your Company while you are on site at your Company, an additional benefit equal to the lesser of 50% of the full amount of coverage or $25,000 is payable. This benefit will be paid in a lump sum to you, if alive, otherwise to your Beneficiary.

Exclusions – MetLife

Applies to the following plans:

- Basic Accidental Death and Dismemberment (AD&D)
- Voluntary Accidental Death and Dismemberment (VAD&D)

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

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

Other Information – Under the MetLife Plans

Naming your Beneficiary

You may name anyone as your Beneficiary and you may change your Beneficiary designation at any time by completing the appropriate form available from the Pantex Benefits Office. Forms are also available on the Company's internal Benefit Plans website.

For GUL Coverage, you will need to contact MetLife to name or change a Beneficiary designation.

For all Life and Accident Coverage, except GUL, the Beneficiary you name for Basic Life Insurance benefits will automatically be your Beneficiary, unless you elect otherwise in writing. This includes Business Travel Insurance and Special Accident Insurance.

If you do not designate a Beneficiary or if you do not have any living Beneficiary(ies), benefits will be paid to your estate, except for GUL, Business Travel Accident, and Special Accident Insurance benefits, which will be paid to the first survivor among the following Beneficiaries:

- Your Spouse
- Your Child or Children
- Your mother or father
- Your sisters or brothers

You will automatically be the Beneficiary in case of the death of a family member, unless you elect otherwise in writing.

Costs for Coverage

As described in the "About Your Benefits" section, you and the Company share the cost for some plans and the Company pays the cost for others.

The Company pays the cost for Basic AD&D and Business Travel Accident Coverage.

Tax Consequences

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

Imputed income does not apply to Accidental Death and Dismemberment Coverage.

Living Benefit

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

You may receive up to 80% of the amount of your Basic Life and GUL Coverage, with a maximum living benefit of $500,000 of your Basic Life Insurance coverage and $500,000 of your GUL Insurance coverage. Benefits will be paid in a lump sum. Living benefit payments may be taxable and may affect your eligibility for certain government benefits, such as Medicaid. In addition, the amount of benefits payable to your Beneficiary upon your death will be reduced by the amount of the living benefit that you receive.

If you wish to apply for a living benefit, please contact the Pantex Benefits Office for forms and instructions for Basic Life Coverage. Please contact MetLife for forms and instructions for GUL Coverage. This is also known as the Accelerated Benefits Option (ABO).

Payment of Benefits

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

Conversion Privileges

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

If your GUL, Spouse, or Dependent Child GUL terminates and you did not elect the Portability of Coverage Provision, or the Case Termination Provision, or reduced coverage amounts due to age reductions, or class changes or plan amendment, you may apply to convert all or part of these coverages to individual insurance policies within 31 days after termination of coverage without taking a medical examination. You may contact MetLife to obtain conversion information.

Basic AD&D, VAD&D, and Business Travel Accident Insurance may not be converted.

Portability

Basic Life and Group Universal life

Although premiums may differ from what you are currently paying, the cost to continue your Basic Life and GUL Coverage under the portability option is generally less expensive than converting to an individual Life Insurance Policy. When you elect to continue coverage under the Portability Option you will not lose the valuable features of the TCA (see Payment of Benefits) or the ABO (see Living Benefit).

Basic Life and AD&D

For Basic Life and AD&D Insurance, the amount available under the Portability Provision is the amount of coverage you had at the time your benefits ended or when you lost coverage due to a benefit reduction upon your retirement.

At the time you elect the Portability Provision option, you may elect an increase in your eligible Life Insurance coverage in increments of $25,000, up to a maximum ported amount of $2,000,000. Once you select a coverage amount, you may only decrease coverage in the future; you cannot increase the amount.

To be eligible for this increased amount, you must provide satisfactory evidence of your insurability to MetLife, at your expense. If MetLife approves the increase, it will take effect on the date MetLife confirms in writing.

Group Universal Life, Spouse, and Dependent Child GUL

The GUL, Spouse, and Dependent Child GUL can continue on a direct bill basis if coverage ends due to retirement, termination of employment, or disability. Under the Portability Provision, the minimum amount of coverage that you can port is $20,000 and the maximum is the amount of GUL Coverage you had at the time your GUL benefits ended.

Once you select a coverage amount, you may only decrease coverage in the future; you cannot increase the amount.

If your GUL benefits terminate, you may contact MetLife to discuss your options under the features of the Plan.

Note: You may continue GUL coverage by either porting or converting the coverage to an individual policy. If you elect portable coverage and it is reduced or ends due to age, new conversion rights may be triggered.

When Coverage Ends

Basic Life Insurance ends on the date your employment terminates for any reason other than Total and Permanent Disability.

Group Universal Life Insurance coverage can continue on a direct bill basis at retirement or termination of employment or disability. You will need to contact MetLife to determine any action you need to take for your individual situation and within what timeframe.

Dependent Spouse or Child GUL Insurance coverage ends the earlier of the date a written request to terminate the coverage is received, the date the Spouse turns 100, the date the insured Spouse or Child ceases to meet any of the eligibility requirements or the date of the Employee's death. You will need to contact MetLife to determine any action you need to take for your individual situation and within the required timeframe.

Basic Life Insurance, Accidental Death and Dismemberment (AD&D), Voluntary Accidental Death and Dismemberment (VAD&D), and Group Universal Life

Benefits will be paid if you should die in a circumstance or event otherwise covered by these Life Insurance benefits within the 31-day period after your coverage terminates.

Business Travel Accident Insurance

Provided through NY Life

Benefits are payable to your Beneficiary in case of your death as a result of an accident that occurs while you are traveling on a Business Trip (as defined in the Glossary). This does not include commuting to or from work. If your Spouse and/or Eligible Dependent Children are authorized to travel with you, they may also be covered for accidental death or dismemberment. Business Travel Accident Insurance pays benefits to you if you should lose sight, speech, hearing, or limb or become paralyzed or totally and permanently disabled.

Coverage is provided 24 hours a day during a Business Trip (as defined in the Glossary), starting when you leave your home or place of business (whichever is later) and continuing until you return to your home or place of business (whichever is earlier). Coverage is also provided while you are on a side trip or vacation that is taken in conjunction with a Business Trip, or on the Company premises to which you are permanently assigned in the event of a bomb scare, bomb search, bomb explosion, or felonious assault (committed by someone other than a fellow Employee or family member).

Business travel accident insurance benefits are paid in addition to any other Life and Accident Insurance benefits you are eligible to receive.

Benefit Amounts

You – While you are actively employed, and until age 70, your business travel accident benefit amount equals four times your annual Pay, with a minimum benefit of $50,000 and a maximum benefit of $500,000. In a Company aircraft accident, your minimum benefit is $100,000.

Your Spouse – Your Spouse's benefit amount is $50,000, and the benefit amount for each Eligible Dependent Child is $25,000. In a Company aircraft accident, however, their individual benefits increase to $100,000.

A combined maximum benefit of $5,000,000 is payable on behalf of all covered individuals in one aircraft accident. Therefore, for any aircraft accident in which more than $5,000,000 is claimed, there will be a proportionate distribution of the $5,000,000 maximum. In addition, a combined maximum benefit of $10,000,000 is payable on behalf of all covered individuals involved in on premises Terrorism, on premises Bomb Scare, Search, Explosion, or on premises Felonious Assault Accident. Therefore, for any such accident in which more than $10,000,000 is claimed, there will be a proportional distribution of the $10,000,000 maximum for those eligible.

As an active employee age 70 and older, your benefit will be this percentage of your pre-70 benefit:

Age 70 – 82.5%
Age 75 – 57.5%
Age 80 – 37.5%
Age 85 – 20.0%

Dismemberment Benefits

If you, your Spouse, or your Eligible Dependent Child(ren) should lose sight, speech, hearing, or limb or become paralyzed as a result of and within one year after an accident which occurs while you are traveling on a Business Trip, you, your Spouse and your Eligible Dependent Children will receive the following benefits.

- The benefit will be paid at 100% in a lump sum for the following loss:
  - Any combination of one hand, one foot, or sight of one eye
  - Both hands, both feet, or sight of both eyes
  - Both speech and hearing (both ears)
  - Quadriplegia (total paralysis of both upper and lower limbs)
- The benefit will be paid at 50% in a lump sum for the following loss:
  - One hand, one foot, sight of one eye, speech, or hearing (both ears)
  - Paraplegia (total paralysis of both lower limbs) or Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
- The benefit will be paid at 25% in a lump sum for the following loss:
  - Thumb and index finger of same hand

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable. For example, if you sustain an injury that entitles you to 25% of your benefit amount and another from the same accident that entitles you to 50%, you will be paid 50% of your benefit amount.

"Loss" is defined in the Glossary.

Payment of Benefits

Death Benefits

If you should die as a result of and within one year after an accident which occurs while you are traveling on a Business Trip, the full amount of your business travel accident benefit will be paid to your Beneficiary in a lump sum. In the event of your Spouse's or Eligible Dependent Child's death, you will receive their full benefit amount.

Note: Unless you have otherwise submitted in writing, your Beneficiary will be the Beneficiary designated under your Basic Life Benefit.

Seat Belt Benefit

An extra benefit is payable if you or an Eligible Dependent on a Business Trip dies as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If the eligible person was wearing a seat belt (or protected by a child restraint as defined by state law) certified in the official report of the accident, or by the investigating officer at the time of the accident, that person's benefit will be increased 10%, up to an additional $10,000. If it is unclear whether the eligible person was wearing the required protection, the Plan will pay $1,000 to the Beneficiary.

Total and Permanent Disability Benefits

- If within 365 days of a covered accident you become Totally and Permanently Disabled as a result of an injury sustained in the accident, you will receive a lump-sum payment after you have been Totally and Permanently Disabled for 12 consecutive months. The amount of this payment will be your full benefit amount, less any other amount payable from this plan as a dismemberment benefit for the same accident.
- You must have been under age 70 at the time of the covered accident to receive Total and Permanent Disability benefits under this plan.

Exclusions

Business travel accident benefits are not payable for losses or death caused by:

- Illness or disease
- Bacterial infections; this exclusion does not apply to infection in an accidental cut or wound, or due to food poisoning
- Commission of a common law felony by the covered individual
- Intentionally self-inflicted injury or suicide
- Flying in a rocket-propelled aircraft
- Flying in any private aircraft being used on Company business
- Crop dusting
- War or any act of war in the United States or any nation of which you permanently reside (there is war risk coverage outside the United States); this exclusion does not apply to the hijacking or air piracy of any conveyance used during a covered trip or Acts of Terrorism while traveling on a covered trip, or on any premises of the Company
- Service in the armed forces of any country
- A motor vehicle accident, if driving is a primary duty of your occupation (e.g., truck driver, courier, etc.)
- Commuting to and from work
- Flying in any aircraft other than a properly licensed and piloted commercial, chartered, corporate, or other Company-approved aircraft.

Travel Assistance Services – Business Travel

Travel assistance services are available 24 hours a day, 365 days a year while traveling on Company business at least 100 miles from your place of residence. Services range from pre-departure information to replacing lost passports to coordinating emergency medical evacuations. Please call 1-888-226-4567 within the United States and Canada or call collect 1-202-331-7635 from any other location. Travel assistance services are provided by New York Life Benefit Solutions (NYL GBS) Secure Travel under a contract with General Global Assistance. Emergency services must be coordinated through NYL GBS Secure Travel.

This program is not insurance and does not provide reimbursement of expenses for financial loss. A covered Employee is responsible for any advances, payments, travel-related or replacement costs, and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available credit limit to cover the amount of the advance.

Emergency Medical Evacuation

When necessary, NYL GBS Secure Travel will arrange and pay for your transportation to the nearest adequate medical facility that can properly treat your condition.

Repatriation Benefit

If you die while traveling, NYL GBS Secure Travel will arrange and pay for all necessary government authorization, and pay for the return of your remains to your place of residence for burial.

Special Accident Insurance

(PGU Bargaining Unit Only)

Provided through NY Life as a Benefit Rider to Business Travel Insurance as a voluntary plan

Special Accident Insurance is available on a voluntary basis. This coverage provides extra financial security for you and your family in the event of accidental death, dismemberment, or paralysis.

Coverage is provided 24 hours a day anywhere in the world, on or off the job, on business or vacation, and at home.

Special Accident Insurance benefits are paid in addition to any other Life and Accident Insurance benefits you are eligible to receive.

Coverage Amount

You can elect Special Accident Insurance coverage from $20,000 to $500,000 in $10,000 increments. You may elect coverage greater than $250,000, only if the amount you choose does not exceed ten times your annual Pay.

If you want to cover your Spouse and Eligible Dependent Children, you can elect family coverage. The benefit amount for family members is a percentage of your benefit amount and is based on the composition of your family at the time of loss, as follows:

If you have these dependents at the time of loss:	Your Spouse's benefit will be:	Each Child's benefit will be:
Spouse and Children	90%	20%
Spouse only	100%	n/a
Children only	n/a	30%

As an active Employee age 70 and older, your benefit amount will be reduced as follows:

If you are at least this age:	Your benefit will be this percentage of your pre-age-70 benefit:
70	82.5%
75	57.5%
80	37.5%
85	20%

Your premiums for Special Accident Insurance will not be reduced when your benefit is reduced.

Payment of Benefits

Death Benefits

If you or a covered Eligible Dependent should die as a result of and within one year after an accident, the full benefit amount is payable to you or your Beneficiary, as applicable, in a lump sum. If you and your covered Spouse should both die in the same accident or separate accidents that occur within a 24-hour period, your Spouse's benefit will increase to 100% of your benefit. However, the combined benefit will not be more than $1,000,000.

Seat Belt Benefit

An extra benefit is payable if you or a covered Eligible Dependent die as a result of injuries sustained while driving or riding in a private passenger car equipped with seat belts. If the covered person was wearing a seat belt (or protected by a child restraint as defined by state law) at the time of the accident, that person's benefit will be increased 10%, up to an additional $10,000.

If it is unclear whether the covered person was wearing the required protection, the Plan will pay $1,000 to the Beneficiary.

Child Care Center Benefit

If you elect family coverage and you or your Spouse die as a result of an accident, an additional annual benefit of up to 3% of your Special Accident Insurance benefit (to a maximum of $5,000 per year for each Child) will be payable for a licensed child care center to care for your surviving Child.

To be eligible for this payment, your Child must have been enrolled in a legally licensed child care center prior to your death (or your Spouse's death) or within 365 days thereafter. This benefit will be paid once a year for up to four years, or until your Child reaches age 13, whichever comes first.

After the Child has been in child care for 12 months following the accident, the claim for child care should be submitted to the Pantex Benefits Office for reimbursement. If the surviving Spouse has custody of the Child, benefits will be paid to the surviving Spouse. If there is no surviving Spouse or the Child does not live with the Spouse, benefits will be paid to the Child's legally appointed guardian.

If you had family coverage at the time of the accident, but no Children are eligible for the child care benefit, a one-time $1,500 payment will be made to your Beneficiary.

Education Benefit

If you elect family coverage and then lose your life as the result of an accident, an annual education benefit of an additional 5% of your benefit amount, up to $15,000 a year, is payable on behalf of any dependent Child who, on the accident date, is:

- Enrolled as a full-time student in any institution of higher learning beyond the 12th grade.
- Enrolled in the 12th grade and, within 365 days after the accident, enrolls as a full-time student in an institution of higher learning beyond the 12th grade.

Benefits are payable for four years provided your Child remains a full-time student.

If you have family coverage at the time of the accident but no dependent Children who qualify for the education benefit, your Beneficiary will receive an additional $5,000 lump-sum benefit.

Spouse Retraining Benefit

If you elect family coverage and then lose your life as the result of an accident, a "Spouse Retraining Benefit" is payable to your surviving Spouse who enrolls in any professional or trade school or training program in order to obtain an independent source of income and support. The Plan will pay up to $5,000 toward the cost of training received within 30 months after the date of your death.

Surviving Spouse Benefit

If you choose family coverage and you or your covered Spouse dies as a result of an accident, an additional 1/2% of your Special Accident Insurance amount will be payable to the surviving Spouse each month for 12 months.

Continuation of Special Accident Coverage After Employee's Death

If you choose family coverage and you die as a result of an accident, coverage for your eligible Spouse and Children will continue, at no cost, for 36 months.

Dismemberment Benefits

If you or a covered Eligible Dependent should suffer a loss as a result of and within one year after an accident, you or your family member will receive the following benefits in a lump sum:

- The benefit will be paid at 100% in a lump sum for the following loss:
  - Any combination of one hand, one foot, or sight of one eye
  - Both hands, both feet, or sight of both eyes
  - Both speech and hearing (both ears)
  - Quadriplegia (total paralysis of both upper and lower limbs)
- The benefit will be paid at 50% in a lump sum for the following loss:
  - One hand, one foot, sight of one eye, speech, or hearing (both ears)
  - Paraplegia (total paralysis of both lower limbs) or Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
- The benefit will be paid at 25% in a lump sum for the following loss:
  - Thumb and index finger of same hand

If two or more of these losses are sustained in the same accident, your benefit amount will be for the loss with the largest percentage amount payable. If your Covered Dependent Child suffers a dismemberment loss as described above, the Plan will pay double the benefit amount indicated up to a maximum of $200,000.

"Loss," "Paralysis," and "Limb" are defined in the Glossary

Total and Permanent Disability Benefit Feature

If within 365 days of a covered accident you become Totally and Permanently Disabled as a result of an accident, you will receive a monthly benefit after you have been Totally and Permanently Disabled for 12 consecutive months. The amount of this monthly benefit is 2% of your benefit amount, up to $5,000 a month with a maximum of $250,000. Benefits are payable for up to 50 months or until you recover, whichever comes first.

If you should die before receiving the maximum benefit – 100% of your benefit amount – your Beneficiary will receive the remaining benefit.

You must have been under age 70 at the time of the covered accident to receive Total and Permanent Disability benefits under this plan.

There are no Total and Permanent Disability benefits for dependents.

Rehabilitation Benefit

If you or an Eligible Dependent are injured as a result of an accident, an additional benefit of up to $50,000 will be payable for approved rehabilitation expenses incurred within two years of the accident.

Covered Expenses include physical therapy, home reconstruction, and outfitting of special vehicles. This benefit will be reduced by any other rehabilitation benefits that are payable, such as health or accidental insurance, workers' compensation, occupational disease benefits, or similar law.

You must notify the Pantex Benefits Office in writing of your injury before any rehabilitation benefits are payable.

Exclusions

Special Accident Insurance benefits are not payable for losses or death caused by:

- Illness or disease
- Bacterial infection (except an infection resulting from an accidental cut, wound, or ingestion of a poisonous food or substance)
- Intentionally self-inflicted injury or suicide
- Commission of a common law felony by a covered individual
- War or any act of war in the United States; this exclusion does not apply to Acts of Terrorism in the United States
- Service of more than 30 days in the armed forces, other than Reserve or National Guard active duty for training
- Traveling or flying in any aircraft or device, other than hang gliders or parachutes, if the aircraft or device does not have a valid certificate of air worthiness, or is being used:
  - For travel, or is designed for travel beyond the earth's atmosphere
  - Crop dusting; spraying or seeding; firefighting; skywriting; pipeline or powerline inspection; aerial photography or exploration, except for plant site selection or inspections, inventory inspections, and quarry site selection; racing, endurance tests, stunt or acrobatic flying; or any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on)
  - Test or experimental purposes
  - Any military authority [aircraft flown by the U.S. Military Airlift Command (MAC) or similar service, or another country are not excluded]

If the Company requests participation in certain activities listed above, the aircraft exclusions may be modified. However, a $100,000 maximum benefit limitation will apply.

Business Travel and Special Accident Insurance

Naming Your Beneficiary

The Beneficiary you name for Basic Life Insurance benefits will automatically be your Beneficiary for Business Travel Accident Insurance, unless you elect otherwise in writing.

For Special Accident Insurance, you may name anyone as your Beneficiary and you may change your Beneficiary designation at any time by completing the appropriate form available from the Pantex Benefits Office.

If you do not designate a Beneficiary, Business Travel Accident and Special Accident Insurance benefits will be paid to the first survivor among the following Beneficiary(ies): your Spouse; your Child or Children; your mother or father; your sisters or brothers.

If you do not have any living Beneficiary(ies), your Business Travel Accident and Special Accident Insurance benefits will be paid to your estate.

If you elect Dependent Life Coverage or Family Coverage under the Special Accident Insurance Plan, you will automatically be the Beneficiary in case of the death of a family member, unless you elect otherwise in writing.

Costs for Coverage

As described in the "About Your Benefits" section, the Company pays the cost of Business Travel Accident Insurance coverage. You pay the full cost of all Special Accident Insurance coverage.

Tax Consequences

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

Claiming Benefits

You or your Beneficiary must file a claim with the Pantex Benefits Office in order to receive any Life and Accident Insurance benefits. By contacting the Pantex Benefits Office, you or your Beneficiary will receive the necessary forms, as well as instructions and assistance in filing claims.

When Coverage Ends

Business Travel Accident Insurance and Special Accident Insurance coverages end on the date your employment terminates for any reason.

If you are on temporary suspension of work or an approved leave of absence (including Long-Term Disability), you may continue your Special Accident Insurance coverage for 12 months if you pay premiums in advance.

Special Accident Insurance coverage may end before termination of employment. However, this coverage will end on the earliest of the following dates:

- The date you are no longer considered eligible because of a change in your employment status
- You elect not to continue coverage
- The last day of the period for which your last premium was made
- The date the Plan is terminated

Special Accident Insurance coverage for a dependent Child will end the earlier of 120 days after your Child stops being a full-time student or if your Child turns age 28, marries, or begins full-time employment. Employment during school break periods is not considered full-time employment. If the dependent Child is not enrolled in school full-time, coverage for that Child will end at age 18.

Conversion Privileges

Within 30 days after your Special Accident Insurance coverage terminates, you may convert all or part of the coverage to an Individual Insurance Policy without taking a medical examination. The cost for converted coverage will be based on the insurance company's regular premium rates for the type and amount of insurance available to you through the Conversion Privilege. The Conversion Privilege under the Special Accident Insurance Plan ends at age 70.

Contact the Pantex Benefits Office to request a conversion form.

Business Travel Accident Insurance may not be converted.

Claiming Benefits

You or your Beneficiary may contact the Pantex Benefits Office or NY Life to file a Special Accident claim:

NY Life
Life, Accident, Disability
Pittsburg, PA 15222-0328
Telephone: 1-347-708-1824

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Pension Plans

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Pension Plans

Introduction

The Pension Plans help build financial security and provide participants with a source of income throughout their retirement years, based on the participant's plan Eligible Earnings and period of active participation in the particular plan as described in this section.

There are a total of three Pension Plans maintained by the Company for Employees at the Pantex location. The PanTeXas Deterrence Retirement Plan for Non-Bargaining Pantex Location Employees (the "Pantex NB Plan") is offered to eligible non-bargaining Pantex location Employees. The Retirement Plan for Bargaining Unit Employees of the Metal Trades Council of PanTeXas Deterrence, LLC (the "MTC Plan") is offered to eligible Employees covered by the collective bargaining agreement with the Metal Trades Council. The PanTeXas Deterrence, LLC Retirement Plan for Bargaining Unit Members of the Pantex Guards Union (the "PGU Plan") is offered to eligible Employees covered by the collective bargaining agreement with the Pantex Guards Union.

All three Pension Plans may be referred to as the "Pension Plan" or the "Plan" in this Summary Plan Description (SPD) unless specifically referring to a certain plan. All are tax-qualified defined benefit plans that help you prepare for retirement. This SPD is for participants in any of the Plans, although there are specific provisions that may apply to only one of the Plans.

The IRS places certain restrictions on the amount of compensation used and the annual pension benefit you may be eligible to receive. These limits may be adjusted periodically by the IRS.

Plan Eligibility

All Plans are closed to new hires and rehires.

Anyone hired or rehired on or after the applicable Plan's closure is not permitted to participate in the Plans, but will be a participant in a defined contribution plan with "enhanced" Company contributions to take into account the fact the Employee is not accruing pension benefits. Employees who are accruing benefits in a Company Pension Plan will not be eligible for enhanced contributions. The Enhanced Defined Contribution Plan is referred to in this SPD as the "EDC." Because all the Plans are closed, this SPD does not include detailed descriptions of the initial eligibility requirements of each Plan.

Plan Closure Dates:

Pantex Non-Bargaining Plan:	Closed 2/19/2012
Pantex MTC Plan:	Closed 1/1/2016
Pantex PGU Plan:	Closed 1/1/2003

The following individuals were not eligible to become Plan participants:

- Leased Employees;
- Independent contractors;
- Non-resident aliens who do not have earnings from the Company from sources within the United States; and
- Employees who have entered into a written agreement with the Company waiving the right to participate in the Plan.

If you are a Participant in a Pantex Pension Plan, changes to your job classification could impact your continued eligibility as an active Participant.

Service for Prior Management & Operating Contractors at Pantex

If you are an Employee who was employed by Babcock & Wilcox Pantex, LLC as of June 30, 2014, "Company Service" and "Credited Service" will include your continuous service with Babcock & Wilcox Pantex, LLC, as well as any continuous service with Mason & Hanger Co., Inc. If you are an Employee who was employed by Consolidated Nuclear Security, LLC as of October 31, 2024, "Company Service" and "Credited Service" will include your continuous service with Consolidated Nuclear Security, LLC.

Qualified Domestic Relations Orders

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

Cash-out or Rollover of Small Benefits

If you terminate employment and the value of your accrued vested pension benefit is $1,000 or less, the amount will be paid to you in a lump sum without the consent of you or your Spouse. If the amount is between $1,001 and $5,000, you may elect to receive a lump sum. However, if you do not elect to receive a lump sum, you will have an individual retirement account (IRA) set up in your name to receive a rollover of the lump sum. You will not be taxed on the amount of the rollover until you withdraw it from the IRA. If your monthly benefit is less than $125, it will also be cashed out in a lump sum with no further benefits owed.

Service and Earnings During Qualified Military Service Leave

If you are on a qualified military service leave and return to work after the leave within the period provided by law, you will have the option to earn Pension Service Credit for the leave period if, upon your return to work, you make part or all of the required Employee contributions that would have been deducted had you not been on military leave. If you make up only a portion of the contributions, Pension Service Credit is earned on a prorated basis. The contributions will be based on your pensionable earnings you would have received if you were not on military leave. Missed contributions may be deducted over several pay periods. If you received differential pay during the leave, any Employee contributions deducted from the differential pay will reduce the amount you must pay to get full Pension Service Credit for the period. If you do not make up the contributions, your Pension Service Credit will be adjusted.

If you have a Qualified Military Service Leave, please contact the Pantex Benefits Office. You may also contact the U.S. Department of Defense, Employer Support of the Guard and Reserve, at 1-800-336-4590 (website: www.esgr.mil) about your military service rights and responsibilities under USERRA (Uniformed Services Employment and Reemployment Rights).

Withholding Taxes

Under federal tax law, federal income taxes must be withheld from Plan payments, unless you elect otherwise. You may contact the Pantex Benefits Office for more information about tax withholding.

Direct Deposit of Payments

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

Change of Address

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

Administrative Information

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

Applying For Benefits

Upon request, the Pantex Benefits Office will provide you with the necessary information and instructions for receiving benefits and completing payment forms. In case of your death, your Spouse, other Beneficiary or personal representative should notify the Pantex Benefits Office and request information about any Plan benefits that might be payable as a result of your death. If the appropriate forms are not completed and submitted, or if any information requested by the Pantex Benefits Office is not provided, benefits will be delayed.

Note Regarding Social Security

Social Security retirement benefits are in addition to benefits paid from the Plan and are not affected by benefits paid or payable from the Plan. Social Security provides retirement benefits to you and your eligible Spouse based on earnings covered under the law. The retirement age for full Social Security benefits is based on the year you were born. If you were born before 1938, full Social Security retirement benefits can start at age 65. For Employees born after 1937, the age for unreduced Social Security benefits will gradually increase from age 65 to age 67. Ultimately, for Employees born after 1959, full Social Security benefits will not become payable until age 67. Reduced benefits are available as early as age 62. You should consult with the Social Security Administration to determine the age at which you may receive full benefits. Social Security Disability benefits may also be provided to you and eligible family members.

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

Credited Service And Severance From Service

Credited Service (as defined in the Glossary) generally means the time you work for the Company (or a prior Management and Operating Contractor that sponsored the Plan). It may also include time with entities which are related to the Company (or a prior Management and Operating Contractor) or as a Leased Employee. However, that Credited Service does not count for purposes of determining the amount of your benefit, and therefore does not add to your Pension Service Credit.

A severance from service occurs:

- The day you quit, retire, are discharged, or die
- One year after your first day of absence due to layoff, or, if earlier, the first day after recall if you fail to return to work
- One year after your first day of absence while on an approved leave, or, if earlier, the first day after the final day of leave if you fail to return to work

If you are reemployed within one year of your date of severance and you were vested at the time of termination, you will receive Credited Service and Company Service for your period of severance, and your prior service will be restored.

In general, if you are reemployed more than one year after your date of severance and you were vested as of that date, your *prior* Credited Service and Company Service will be restored automatically upon reemployment, regardless of your period of severance. You will not earn Credited Service or Company Service during a period of severance lasting one year or more. In no instance will Pension Service Credit be granted during a period of severance.

If You Retire From A Pantex Plan

Pantex Non-Bargaining Plan

The Pantex NB Plan provides benefits to Employees who are not represented by a bargaining unit and were hired prior to February 19, 2012, unless otherwise noted in this section. Only Pension Service Credit on or after October 1, 1991, is eligible for benefit accrual purposes under the current formula in this Plan. The amount of the benefit for participation on or after October 1, 1991, is equal to 1.3% of your Final Average Earnings (for explanation, see later in this section **Calculate Your Earnings for Pantex Plan Benefits**) multiplied by your years of Pension Service Credit (only service since October 1, 1991, while you were an active member in the eligible class). Employees with service prior to October 1, 1991, who participated in the Mason & Hanger-Silas Mason Co., Inc. Retirement Plan for Non-Bargaining Employees at Pantex Plant or the Mason & Hanger-Silas Mason Co., Inc. Retirement Plan for Non-Bargaining Employees at United States Government Owned Plants (the "Prior Plan(s)") may have an additional benefit. In no event will the Prior Plan(s) benefit be less than your required contributions plus the interest payable as provided in the Prior Plan.

If you were not 100% vested in your accrued benefit as of February 19, 2012 (date of closure), your accrued benefit was frozen and you became eligible for the EDC. Your Credited Service and pay after February 19, 2012, are not recognized for purposes of Final Average Earnings or benefit accruals, but Credited Service after date of closure will continue to count for vesting purposes.

You are vested in the Pantex NB Plan after five years as an Employee, and are always vested in your own contributions and interest as payable in the Plan.

If you were hired or rehired on or after February 20, 2012, you are not eligible to participate in the Pantex NB Plan. If you transferred from a bargaining unit employee classification to an exempt supervisory employee or a non-exempt non-bargaining unit employee classification on or after February 20, 2012, you can elect whether to participate in the Pantex NB Plan or in the Enhanced Defined Contribution program under the Pantex Non-Bargaining 401(k) Plan.

Employee contributions resumed after December 31, 2014, as detailed below:

Employment Classification:	Required Contribution:	Effective Date:
Non-Bargaining Employees	2.0%	1/1/2015 – 12/31/2015
Non-Bargaining Employees	1.0%	1/1/2016 – Ongoing

Contributions are required to receive Pension Service Credit which is used in the pension calculation. If you are on an unpaid leave of absence, other than Qualified Military Service Leave, your period of absence will not count as Pension Service Credit and your Pension Service Credit will be adjusted for the period of leave. See the earlier section, Service and Earnings During Military Service Leave, for details on how Pension Service is calculated for a period of a Qualified Military Service Leave.

MTC Plan

The MTC Plan provides benefits to Employees who are members of the eligible class hired prior to January 1, 2016 (date of closure), as defined by the MTC collective bargaining agreement. Participants will continue to accrue benefits under the MTC Plan as long as they remain in the eligible class. Only MTC Plan participation after March 1, 1993, is considered when determining dates of participation in the MTC Plan for calculating accrued benefits. For that period of participation, you will accrue a benefit equal to 1.3% of Final Average Earnings (for explanation, see **Calculate Your Earnings for Pantex Plan Benefits**) times your years of Pension Service Credit (only counting service as an active member in an eligible class) on or after March 1, 1993.

If you were covered by the MTC Plan prior to March 1, 1993, and made the required contributions, you may also be due a benefit under the contributory portion of the MTC Plan. In no event will the benefit

under the contributory portion of the MTC Plan be less than your required contributions plus the required interest payable under the Plan.

You are vested in the MTC Plan after five years as an Employee, and are always vested in your own contributions.

If you were hired, rehired, or transferred from a non MTC employee classification on or after January 1, 2016, you are not eligible to participate in the MTC Plan.

PGU Plan

The PGU Plan provides benefits to Employees who are members of the eligible class who were hired, transferred, or who accepted employment with the Company prior to March 18, 2002 (date of closure), and did not opt out of the PGU Plan prior to January 1, 2003.

Only PGU Plan participation after June 1, 1994, is considered when determining Pension Service Credit in the PGU Plan for calculating accrued benefits. For that period, you will accrue a benefit equal to 1.5% of Final Average Earnings (for explanation, see **Calculate Your Earnings for Pantex Plan Benefits**) times your Years of Pension Service Credit on or after June 1, 1994, provided you: (1) did not decline participation in the Plan, (2) are not eligible for an enhanced matching contribution in a 401(k) plan, and (3) you were credited with an hour of service in the eligible class as an active member on or after March 18, 2002.

If you were credited with an hour of service as an active member in the eligible class on or after June 1, 1994, and continued participation in the PGU Plan, you will accrue a benefit for that period of participation equal to 1.5% of Final Average Earnings times your years of Pension Service Credit under the PGU Plan.

If you were credited with an hour of service as an active member in the eligible class on or after June 1, 1994, and declined continued participation in the PGU Plan as of March 18, 2002, you will accrue a benefit equal to 1.5% of Final Average Earnings times your years of Pension Service Credit under the PGU Plan for Pension Service Credit between June 1, 1994, and March 17, 2002.

You are vested in the PGU Plan after five years as an Employee, and you are always vested in your own contributions.

In no event will the Prior Plan benefit be less than your required contributions plus the required interest payable under the Plan.

If you were hired, rehired, or transferred from a non PGU employee classification on or after March 18, 2002, you are not eligible to participate in the PGU Plan.

Calculating Your Service for Pantex Plan Benefits

Your Credited Service determines your vested interest in the Plan(s) benefit; your Company Service determines your eligibility for Early Retirement. If you change jobs and are eligible to participate in another Pantex Plan which covers the new job (prior to plan closure dates), your Pension Service Credit for each Plan only includes the time you work in a job covered by that Plan.

If you remain an Employee but change employee classification and are not accruing plan benefits because the new classification is not covered by the Plan, you will be credited with a partial year of Credited Service for the portion of the 12-month period you were employed in a classification covered by the Plan.

Calculating Your Earnings for Pantex Plan Benefits

The amount of your benefit is based on Plan Pension Service Credit and Eligible Earnings that are paid to you in the calendar year. Your Eligible Earnings over a period are averaged and your benefit is then calculated using your Final Average Earnings. The Glossary describes the definitions of “Eligible Earnings” in each Pantex Plan and also how Final Average Earnings are calculated for each Pantex Plan.

If the Employee terminates on or after December 15th of a calendar year, the Employee's Eligible Earnings in that year will be counted in determining Final Average Earnings if higher than earnings for a previous eligible year.

When You Can Retire

You cannot begin to receive pension benefits until you have terminated employment and have a bona fide retirement unless you are age 70 $^{1}/_{2}$. If you expect to return to work after you retire or there is any understanding that you will come back to work for the Company in any capacity, your retirement will not be considered a bona fide retirement that allows you to commence a retirement benefit under IRS requirements. Thus, the Company will request information when you apply for benefits to ensure you have a bona fide retirement.

Reemployment after Retirement

If you retire and subsequently return to work, your benefit will not be suspended as long as you had a bona fide retirement before returning to work. When you again retire, your benefit will not be increased if your second period of service was not covered under the Plan for benefit accrual purposes.

Pantex Non-Bargaining Plan and MTC Plan Retirement Eligibility

You can retire with a **full** (unreduced) pension benefit upon retirement on or after reaching your Normal Retirement age (age 65).

You can retire with a **reduced** early retirement pension benefit beginning as early as age 55 if on your termination date, you have attained at least 120 one-month periods of service in the Pantex NB Plan or 10 years of service in the MTC Plan. You are credited with a year of service in the MTC Plan for each 12-month period (based on your date of hire) in which you are credited with at least 1,000 hours of service.

If you meet the age and service requirements and begin your pension prior to age 65, your pension benefit will be reduced by 2.5% for each year (and pro-rated for a partial year) that benefits commence prior to your normal retirement age. The reduction will not apply if, when you retire, you are classified as a "Firefighter, Motor Pump Operator, or Firefighter/Paramedic who is a responder." In that case you will receive the amount of your accrued benefit without reduction for commencement before age 65 if you otherwise meet the age and service requirements for Early Retirement.

If you leave the Company for any reason after completing at least five years of Credited Service, you are "Vested." Being vested means you have a non-forfeitable right to receive a pension benefit, but not any other retirement benefits, including retiree medical. You are always vested in your contributions and interest payable as provided by the plans. At age 65, you can commence a full pension benefit. Between ages 55–64, you can commence a reduced pension benefit if you have at least 120 one-month periods of service.

PGU Plan Retirement Eligibility

You can retire with a **full** (unreduced) pension benefit on or after reaching your Normal Retirement age (age 65). You can also retire with a **full** (unreduced) pension at age 55 or later and before age 65 if you have attained at least 10 years of service as of your termination date. You are credited with a year of service for each 12-month period (based on your date of hire) in which you are credited with at least 1,000 hours of service.

If you do not meet the requirements above for an unreduced benefit at the time you terminate employment but are vested in your benefit, you may commence a reduced benefit as early as age 55. Your pension benefit will be reduced by 2.5% for each year (and pro-rated for a partial year) that benefits commence prior to your Normal Retirement age. There is no reduction if you wait to commence the pension benefit at age 65.

Working Past Your Normal Retirement Age

If you continue working after age 65 and are still participating in either the Pantex MTC or PGU Pension Plans, you will continue to earn Pension Service Credit and have your earnings counted for pension

benefit purposes until you actually retire. An active Employee who has attained age 70 $^1/_2$ may commence a pension benefit while continuing employment. This benefit is payable beginning with the earlier of the month following the month in which you retire, or April 1 following the calendar year during which you reach age 70 $^1/_2$. This benefit will be recalculated annually to reflect additional service and earnings. The amount of the benefit at late retirement generally will not be less than the Normal Retirement benefit adjusted on an actuarial basis as of the date of actual retirement. A final benefit calculation will be made upon termination of employment.

If you continue working after age 65 and are participating in the Pantex Non-Bargaining Plan, you will continue to earn Pension Service Credit and have your earnings counted for benefit purposes until you actually retire. An active Employee who has attained age 70 $^1/_2$ may commence a pension benefit while continuing employment. This benefit is payable beginning with the earlier of the month following the month in which you retire, or the month following the month in which you attain age 70 $^1/_2$. This benefit will be recalculated annually to reflect additional service and earnings. The amount of the benefit at late retirement generally will not be less than the Normal Retirement benefit adjusted on an actuarial basis as of the date of actual retirement. A final benefit calculation will be made upon termination of employment.

Withdrawal of Your Contributions to Prior Plan(s) Before Commencing Retirement Benefit

The Pantex Plans required Employee contributions for periods of time until the following dates:

- Non-Bargaining plan required contributions until October 1, 1991, and permitted them until January 1, 1992;
- MTC Plan required contributions until March 1, 1993; and
- PGU Plan required contributions until June 1, 1994.

Pension benefits associated with these prior contributory periods are referred to as the Prior Plan(s) contributions. You may be able to withdraw your contributions to the Prior Plan(s) under certain circumstances which are outlined below.

For the Non-Bargaining Plan, if you made contributions under the Prior Non-Bargaining Plan (prior to January 1, 1992, and participated in the Non-Bargaining Plan), and you terminate service prior to Early Retirement age, you may elect to either (1) leave your Prior Plan contributions in the Plan until your Normal Retirement Date, or (2) withdraw your Prior Plan contributions before your Early or Normal Retirement date. If you elect to leave your Prior Plan contributions in the Non-Bargaining Plan, you may change this election and elect to withdraw your Prior Plan contributions prior to reaching age 55. Once you reach age 55, you cannot withdraw your Prior Plan contributions and interest out of the Non-Bargaining Plan until your Normal Retirement date.

For the PGU and MTC Plans, if you made Prior Plans contributions prior to the dates noted above, and you terminate service prior to Early Retirement age, you may elect to either (1) leave your Prior Plans contributions in the plans until your Normal Retirement date, or (2) withdraw your Prior Plans contributions before your Early (or Normal) Retirement date. If you were hired prior to January 1, 1987, you can withdraw your Prior Plans contributions at any time after termination of employment prior to starting your monthly annuity. If you were hired after January 1, 1987, and you elect to leave your Prior Plans contributions in the Plans, you may change this election and elect to withdraw such contributions prior to reaching Early Retirement age, but once you reach Early Retirement age, you cannot withdraw your Prior Plan contributions.

A special rule applies for the PGU and the MTC Plans for persons who were active participants in the Plans prior to April 25, 1964. In that case, if you are an active participant in the Plan and you were an active participant in the Plan prior to April 25, 1964, you may elect to withdraw your Prior Plan contributions plus interest at any time. The portion of your accrued pension attributable to your Prior Plan contributions will be canceled. However, the portion of your accrued pension attributable to Employer contributions will not be affected by the withdrawal. You will remain a participant in the Plan, but no additional benefits will be credited to you for one year. Prior to your termination or retirement, you may

repay the amount withdrawn in a lump sum together with interest, from the date your withdrawal was made to the date of repayment, and your benefit provided by your Prior Plan contributions will be restored.

Your pension benefit under the Pantex Plan will be reduced to reflect any withdrawal of your Prior Plan contributions prior to starting your benefit. Your Spouse's consent is required to make a withdrawal. If your Prior Plan contributions were more than $1,000 and you are married, your Spouse must provide written consent to any early withdrawal of the Prior Plan Contributions. Such consent must be notarized and the consent must acknowledge the effect of the election upon the Spouse.

If you elect to leave Prior Plan contributions in the Pantex Plan, such contributions and their accrued interest will be included in the calculation of your accrued benefit at your Normal Retirement date.

Normal Forms of Payment of Pantex Pension Plans

For Married Employees

Qualified Joint and Survivor Annuity: If you are married on your commencement date, the regular form of payment will be paid under the joint and 50% survivor option. Under this form of payment, your normal pension is reduced and, after your death 50% of your benefit is continued to your surviving Spouse for the remainder of his or her life. This option may be waived in favor of an Alternative Benefit Payment Option with written and witnessed or notarized consent of your Spouse.

For Single Employees

If you are single, the normal form of payment is a single life annuity providing benefits only for your life. Under this form of payment, your benefit is more than if you had a survivor. After your death, no benefits are paid to anyone else. This option may be waived in favor of an Alternative Benefit Payment Option.

Alternative Benefit Payment Options

Alternative Benefit Payment Options are available to all eligible Employees. If you are married you must have written and witnessed or notarized consent of your Spouse to elect an Alternative Benefit Payment Option. These calculations are complex and are not described in detail in this summary. Contact the Pantex Benefits Office to have your pension benefit calculated under various options.

At any time before pension benefits commence, you may revoke or change your election subject to your Spouse's written and witnessed or notarized consent. Once you begin your pension benefit payments your election may not be changed.

Life Annuity Option for Married Employees

Under this form of payment, you receive your benefits for your lifetime only. No benefits are paid to survivors after your death. You must have the written and witnessed or notarized consent of your Spouse to elect this option.

Social Security Adjustment Option

Under this payment option, you or your pre-retirement surviving Spouse (that is, a surviving Spouse where benefits had not commenced by the time of your death), may elect payments that are increased before your Social Security date (age 62 or 65, depending on the date selected) and then decreased or stopped after the Social Security date, so that the combined income from the Plan and Social Security is approximately level throughout retirement. Under the Pantex NB Plan, this option is not available if you are eligible to receive disability benefits under the Federal Social Security Act. Payments cease at your death. There is no survivor benefit payable with this option.

Joint Retirement Benefit Option

- Regardless of marital status, you may elect a joint retirement benefit option which will provide benefit payments to you during your lifetime and thereafter to your duly named joint payee if such person survives you. You may elect a survivor option equal to 100%, 75%, 66 $^{2}/_{3}$%, or 50% of the amount paid to you. You must make this election prior to commencing

your pension benefit and it cannot be adjusted if the person you name as your survivor dies before you.

- Under this option, your normal pension benefit will be reduced to provide a survivor benefit.

Certain and Continuous Retirement Benefit Option

- You may elect the 10, 15, or 20-year certain and continuous retirement benefit option which would provide pension benefit payments for your lifetime after you retire. If you die before receiving the minimum number of payments, the remaining payments are made to the designated Beneficiary until the total of certain payments is made.
- Under this option, your normal pension benefit will be reduced to guarantee the number of payments you elected.

If You Become Disabled While Participating In The Plan

Once you reach pension eligibility you may retire under the same conditions as any other participant.

Unless you are both age 70 $^{1}/_{2}$ or older and an active employee at the time you become disabled, Long-Term Disability benefits will stop once pension benefits commence.

For information on how your average monthly Eligible Earnings are calculated, refer to "Calculating Your Earnings Used for Pension Benefits."

Refer to the Disability SPD or contact the Pantex Benefits Office for additional information.

If You Die While Employed or Prior to Commencement of Benefits

If you die while an active Employee or you terminated employment before being eligible for retirement and have not yet commenced benefits, as long as you and your Spouse have been married for at least one year at the time of your death, your Spouse will be eligible for immediate lifetime benefit pension payments:

- If you are an active Employee at the time of your death, you were at least age 45, and completed at least 10 years of service with the Company at the time of your death; or
- If you are a terminated Employee and you terminated employment at or after age 55, completed at least 10 years of service, and had not commenced pension benefits at the time of your death.

The surviving Spouse pension benefit described immediately above will be equal to 50% of the amount of your pension benefit accrued as of the date of death. Other reductions may apply based on which Pantex Plan pays the benefit and the age of you and your Spouse as of your date of death.

If you are married and do not meet the conditions listed above but completed at least five years of Credited Service and had not commenced benefits prior to your death, your Spouse will be eligible for reduced lifetime pension benefits beginning no sooner than the earliest date at which you could have elected a pension benefit. You and your Spouse must be married for at least one year at the time of your death for the surviving Spouse to receive a benefit. The surviving Spouse pension benefit described immediately above will be calculated as 50% of the amount of your pension benefit accrued as of the date of your death, times 2.5% for each year and partial year the pension benefit commences prior to the date you would have reached age 65. Other reductions may apply based on which Pantex Plan pays the benefit and age of you and your Spouse as of your date of death.

Payment Options for Surviving Spouse

<u>Monthly Survivor Annuity for Life of Surviving Spouse</u>

- Calculated as indicated above, based as an immediate commencement or future-date commencement.

<u>Social Security Adjustment Option (Pre-Retirement Surviving Spouse)</u>

- Calculated as the Monthly Survivor Annuity

Lump Sum Payment in Lieu of Pension Benefits

- Within 90 days of your death, your Spouse may elect a lump sum payment in lieu of monthly pension benefit payments. The amount of any lump sum payment will be the actuarial equivalent of the pension benefit payable as a life annuity to your Spouse.

Payment to Beneficiary

- If married, your Spouse shall be presumed to be the Beneficiary unless the Spouse has provided a written and witnessed or notarized waiver or consent allowing such designation.

In no event will Plan payments to you and your Beneficiary in total be less than your contributions to the Plan (and Prior Plan) plus interest payable provided by the Plan.

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401(k) Savings Plan

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The 401(k) Savings Plan offers a convenient, tax-effective way to save and invest for the future. At retirement, 401(k) Savings Plan benefits are designed to work together with other investments and Social Security benefits to provide retirement income.

The 401(k) Savings Plan

Introduction

The Company offers bargaining unit and non-bargaining Employees at the Pantex location a convenient way to save for retirement.

- The PanTeXas Deterrence, LLC 401(k) Plan for Non-Bargaining Pantex Location Employees (the "Pantex Non-Bargaining Plan") is offered to non-bargaining Employees at the Pantex location.
- The PanTeXas Deterrence 401(k) Plan for Bargaining Pantex Location Employees (the "Pantex Bargaining Plan") is offered to bargaining unit Employees at the Pantex location.

If a statement applies to both of these plans, they will be referred to jointly as the "Pantex Plans."

The two plans may be referred to as the "401(k) Plan" or the "Plan" in this Summary Plan Description (SPD), and each is a tax-qualified defined contribution plan that helps you accumulate savings for retirement. This SPD is for Participants in either of the Plans, but has separate provisions when Plan terms vary.

Eligibility

Non-bargaining Employees at Pantex are eligible to participate in the Pantex Non-Bargaining Plan. Bargaining unit Employees at Pantex are eligible to participate in the Pantex Bargaining Plan. The following individuals of the Company are not eligible to participate in either of the Plans:

- Leased Employees
- Ad Hoc Employees
- Employees not receiving wages from the Company
- Nonresident aliens receiving no earned income from the Company that constitutes earned income from sources within the United States
- An Employee who has entered into an agreement waiving participation in the Plan for the period participation was waived
- Interns and co-op students at the Pantex location

If you are eligible to participate in one of the Pantex Plans and transfer to a new job classification without interruption of service that makes you eligible for the other Pantex Plan, you will transfer to the Plan that applies to your new job classification.

Enrolling in the 401(k) Plan

The 401(k) Plan is provided by the Company to encourage retirement savings; however, participation is voluntary. When you begin work, you will receive information about the 401(k) Plan, which includes this SPD and a list of investment options for you to direct the investment of your Plan account. You may enroll at any time after your date of hire. Contributions will begin as soon as administratively feasible.

To enroll in the PXD 401(k) log on to the Recordkeeper website at https://pantex.voya.com or call 1-844-573-8692. From the Home page on the Plan website select Register Now, or from the Information Line select the enrollment option from the main menu. You will then elect:

- The percentage you wish to save
- How you want to save – on a before-tax basis, a Roth after-tax basis, or a combination
- Choose your investments
- If you make no investment choice, your contribution will default to a Target Date Fund closest to your 65th birthday
- Confirm your elections and submit
- Don't forget to elect a beneficiary by clicking on *Personal Information* > *Beneficiary Information*

Automatic Enrollment –Pantex Employees covered by the Pantex Guards Union (PGU) collective bargaining agreement hired or rehired on or after 8/26/2022 will be automatically enrolled in the 401(k) plan at a 10% contribution rate (on a pre-tax basis) unless you contact Voya within 30 days from your hire date.

Pantex Employees covered by the Metal Trades Council (MTC) collective bargaining agreement hired or rehired on or after 5/6/2019 will be automatically enrolled in the 401(k) plan at a 6% contribution rate (on a pre-tax basis) unless you contact Voya within 30 days from your hire date.

Pantex Protective Force Officers who are required to carry a weapon and to maintain physical requirements and are not eligible for the Pantex Guards Union (PGU) Pension Plan (either opted out of the Pension Plan to participate in the Enhanced 401(k) Savings Plan or were hired on or after 3/18/2002) and who are hired or rehired on or after 8/7/2020 will be automatically enrolled in the 401(k) plan at a 3% contribution rate (on a pre-tax basis) unless you contact Voya within 30 days from your hire date.

All other Pantex Non-Bargaining Employees hired or rehired on or after 8/7/2020 will be automatically enrolled in the 401(k) plan at a 6% contribution rate (on a pre-tax basis) unless you contact Voya within 30 days from your hire date.

If you are covered by automatic enrollment provisions and prefer a contribution rate of more or less than your automatic contribution percentage, you must contact Voya to select the contribution percentage you want. If you choose not to participate, you must contact Voya before the end of the 30-day time period to change your contribution percentage to 0%. You may start your contributions prior to the 30-day period by contacting Voya or by logging on to the Voya website. You may also stop your contributions at any time by contacting Voya or make the change on the website.

Annual Increase Plan – PGU Employees hired or rehired between 4/1/2008 and 8/25/2022 and Pantex Protective Force Officers described above hired or rehired on or after 8/7/2020 will be automatically enrolled in the Annual Increase Plan. If your contribution percentage is less than 10%, your percentage will be automatically increased by 1% on April 1st each year (after one full year of service) until you reach a 10% contribution rate. You may choose an alternate date for the annual increase, choose a different increase percentage (full percentages only), or you may decline participation in the Annual Increase Plan by contacting Voya.

If you are not automatically enrolled in the Annual Increase Plan, you may elect automatic annual increases by contacting Voya.

Beginning Deductions and Investment Choices

Your payroll deductions will begin as soon as administratively possible, generally within three pay periods.

Once you have enrolled, your contribution amount and investment choices will remain in effect until you make a change.

A few days after you enroll, a confirmation statement will be sent to your home. Review the statement carefully to make sure your participation and election information is correct.

Naming Your Beneficiary

Your Beneficiary is the person you name to receive benefits from the 401(k) Plan if you die with a vested balance remaining in your 401(k) Plan account. Your Beneficiary can be anyone you wish. If you are a Participant in the Pantex Plan and are married for any length of time, you must obtain your Spouse's written and notarized consent to name someone other than your Spouse. Details about the consent requirements and procedures to make a subsequent change in Beneficiary are available from the Recordkeeper at the website and phone number listed.

Keep your Beneficiary designation up to date. If you do not make a valid Beneficiary designation and are married on your date of death, your Spouse will receive the value of your vested 401(k) Plan account. If you are single and do not name a Beneficiary, your vested 401(k) Plan account will be paid to your estate.

The 401(k) Plan Information Sources

The 401(k) Plan makes saving easy. It lets you enroll and manage your account over the telephone through a voice response unit, by speaking with a Participant Services representative, or by using the Plan's website. By calling Voya Participant Services or by going to the website, you can:

- Enroll in the 401(k) Plan
- Check your account balance and investment performance
- Make investment elections
- Transfer between investment funds
- Change contribution percentages
- Change investment elections
- Request a loan or withdrawal
- Update or change beneficiary information

Voya Participant Services Contact Information

In the United States: 1-844-573-8692

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

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

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

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

You may change your User Name and/or password to personalize it at any time you wish. Your User Name, password, and PIN are confidential and should be kept in a safe place. If you lose your User

Name, password, or PIN, call the number above for assistance in getting them reset. You may also request a password reminder from the website to be mailed or e-mailed to you provided you have set up your e-mail preference. For security reasons, you can never get your PIN over the telephone.

Accessing the System

To log on to your account, go to the Participant log-in screen, enter your user name and your password, and press log in. Every Participant in the Plan will be able to gain access to the Plan, even if you do not have an account balance.

Working with the Plan

After you log on, the system immediately shows the market value of your account as of a particular date. Plan investment funds are valued on each day the stock market is open. The amount shown on the screen is the market value as of the close of business of the previous business day (or the last day the stock market was open). This value is updated only once each trading day, so the value you see in the morning will be the same value for that entire day.

Your Quarterly Statement

After the end of each calendar quarter, you will receive a statement that reports your account activity, total fund balances, and investment elections.

You can use these statements to track the value of your savings.

You also have access to your account statement at any time by visiting the Voya website. You can create an online statement for any period of time within the last 24 months.

Your Contributions

You can contribute to the 401(k) Plan in the following ways:

- Before-tax contributions from your Eligible Earnings
- Roth (special after-tax) contributions from your Eligible Earnings
- Rollover contributions

Eligible Earnings

All earnings are eligible for contributions with the exception of:

- Reimbursements or other expense allowances
- Fringe benefits
- Moving expenses
- Welfare benefits (even if includible in gross income)

Federal tax laws limit the amount of Eligible Earnings that can be counted for Plan purposes. The amount is adjusted by the IRS based on cost-of-living changes. Check the IRS website for limits at www.irs.gov.

Before-Tax Contributions

Your before-tax contributions are deducted from your Eligible Earnings before federal and, in most cases, state and local taxes are determined. (Social Security taxes are not affected.) By saving with before-tax dollars, you reduce your current taxable income and, therefore, your current annual tax liability. The government allows this reduction in taxable income to encourage you to save for retirement. For this reason, withdrawals during your active career with the Company are restricted.

Roth Contributions

Your Roth contributions are deducted from your Eligible Earnings on an after-tax basis. However, earnings on Roth contributions grow tax free if certain distribution requirements are met. Upon

distribution, Roth contributions are distributed free from federal and most state income tax. Earnings on Roth contributions are also tax free if they are withdrawn after age 59 $^{1}/_{2}$ and your Roth account has been open at least five years.

Catch-up Contributions

Participants who will be at least age 50 by the last day of the calendar year are eligible to contribute additional amounts of before-tax or Roth contributions called "catch-up contributions." For assistance in determining whether you qualify to make an additional contribution and the maximum amount of such contribution, contact Voya.

Limitations

There is a limit on the amount of before-tax and Roth contributions that you can make to all Employer Plans (Company Plans and other employer Plans) during any year. The before-tax/Roth contribution limit, which is announced annually, will be adjusted for increases in the cost of living as determined by the federal government. To check the contribution limits, visit the IRS website at www.irs.gov. If you are employed during one year by another employer and make before-tax or Roth contributions to another employer's plan, these contributions also count in the annual contribution limit, and you are responsible to notify the Plan Administrator that you have reached or exceeded your limit. If you have exceeded the limit, you are responsible to request a distribution of the excess amount.

There is also a limit on the total amount of contributions including before-tax, Roth, and Employer matching and enhanced contributions that can be made to your Plan account each year. This annual limit will be adjusted for increases in the cost of living as determined by the federal government. To check the contribution limits, visit the IRS website at www.irs.gov.

Additional limits may apply to highly compensated Employees. You will be notified if these additional limits apply to you.

At Pantex, once you reach the annual before-tax/Roth limit (adjusted if you are age 50 or older and eligible to make additional catch-up contributions), your contributions will automatically be stopped. However, Employer matching contributions will continue as if your own contributions had continued. If you actively elect to stop your contributions by changing your contribution percentage to 0%, the Employer matching contributions will also stop. Unless you elected to stop making contributions (actively changed your contribution percentage to 0%), your contributions will revert back to your original election of before-tax and/or Roth contributions at the beginning of the next calendar year without filing a new election.

Contributions During and After Military Leave

If you receive differential pay while you are on military leave, you may continue to make contributions to the Plan from your differential pay. Such contributions will be eligible for matching contributions.

When you return to work after you have been on military leave, you may be able to make contributions to the 401(k) Plan to make up for contributions you missed while you were on leave and may receive Employer matching contributions on your make-up contributions.

Contact the Pantex Benefits Office for more information if you think this may apply to you. You may also contact the U.S. Department of Defense, Employer Support of the Guard and Reserve, at 1-800-336-4590 (www.esgr.mil) about your military service rights and responsibilities under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Rollovers to the 401(k) Plan

As a general rule, you may roll over taxable and Roth amounts you receive from a tax-qualified plan of a former employer to your 401(k) Plan account if the amounts you received qualify to be rolled over. When you request a withdrawal or receive a distribution from a tax-qualified plan of a former employer, you will receive information telling you that the amount qualifies or does not qualify to be rolled over. You will continue to defer current federal income taxes on the amount you roll over. If you come to work for the Company after working for another employer that has a tax-qualified retirement plan, and you receive

a distribution from the other employer's plan that qualifies to be rolled over, you may direct the transfer of the taxable and Roth portion of your payout directly to the 401(k) Plan or following an interim transfer to a conduit Individual Retirement Account (IRA).

If you received the distribution rather than having it transferred directly to the Plan and the distribution check is payable to you, you may still roll over all or part of the distribution to the Plan, but such rollover must be made within 60 days of the date you received the distribution from the other qualified plan (or conduit IRA). If you miss the deadline, you cannot roll your distribution into the 401(k) Plan and you will have to pay taxes on the taxable portion of your distribution.

To make a direct transfer of a qualified distribution to the 401(k) Plan, you must submit a certified check or a cashier's check from your prior plan's trustee or custodian payable to the Plan (not payable to you), the distribution statement you receive with your rollover check, and a completed rollover contribution form to the Plan Recordkeeper.

Contact Voya at 1-844-573-8692 to obtain the instructions and form for a rollover or print the form from the website.

How Much You Can Save

Pantex Employees may contribute up to 50% of your Eligible Earnings each pay period, subject to the annual contribution limits. You must save in 1% increments.

This percentage may be reduced for highly compensated Employees to satisfy certain Internal Revenue Code tests. You will be notified of the restrictions for each year if they apply to you.

Your contributions are eligible for Company matching contributions, as discussed later in this section.

Changing Your Contributions

You can increase, decrease, or stop your contributions at any time by calling 1-844-573-8692 or online through your account. Changes will be sent to payroll and will be effective as soon as administratively possible, generally within two pay periods. The last election you made before the payroll processes will override any previous elections.

You can suspend or resume contributions at any time. When you resume your contributions, cash deposits to make up for the period of suspension will not be permitted. All contributions must be made by payroll deduction.

If You Contribute to Another Employer's Qualified 401(k) Plan During the Year

If you contributed before-tax and/or Roth contributions to another employer's qualified 401(k) Savings Plan and then begin to contribute to this Plan in the same calendar year, your total annual before-tax and Roth contributions cannot exceed the IRS limit for the year. Be careful to track how much you contribute to this Plan so your total contributions between both plans do not exceed the contribution limit for the year. If you do exceed this limit, immediately contact Participant Services so any excess contribution amount that you made can be refunded by the legal deadline.

If you have questions about refunds, contact Participant Services.

Company Matching Contributions

Each pay period, the Company will contribute a matching contribution as a percentage of your Eligible Earnings contributed to the Plan.

401(k) Company Matching Contributions

Pantex Non-Bargaining Employees (not including Pantex Protective Force Officers)

The Company provides non-bargaining Employees (not including Pantex Protective Force Officers) with a match of your contributions as follows:

- 100% of the first 2% of Eligible Earnings

- 50% of the next 4% of Eligible Earnings
- Maximum match is 4% of Eligible Earnings if you contribute at least 6%
- Amounts contributed over 6% of Eligible Earnings are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 6% of Eligible Earnings for a total Employee contribution of $3,000 per year. The Company has a matching contribution of:

100% of the first 2% of Eligible Earnings:	$1,000 x 100% = $1,000
50% of the next 4% of Eligible Earnings:	$2,000 x 50% = $1,000
Company matching contribution:	$2,000

Pantex Protective Force Officers – (Without Pension Benefits)

The Company provides Pantex Protective Force Officers who are required to carry a weapon and to maintain physical requirements and are not eligible for the Pantex Guards Union (PGU) Pension Plan (either opted out of the Pension Plan to participate in the Enhanced 401(k) Savings Plan or were hired on or after 3/18/2002) with a matching contribution as follows:

- 100% of first 10% of Eligible Earnings
- Maximum match is 10% if you contribute at least 10%
- Amounts contributed over 10% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 10% of Eligible Earnings for a total Employee contribution of $5,000 per year. The Company has a matching contribution of:

100% of the first 10% of Eligible Earnings:	$5,000 x 100% = $5,000
Company matching contribution:	$5,000

Pantex Protective Force Officers – (With Pension Benefits)

The Company provides Pantex Protective Force Officers who are required to carry a weapon and to maintain physical requirements and are eligible for the Pantex Guards Union (PGU) Pension Plan (opted to remain in the Pension Plan and were hired before 3/18/2002), with a matching contribution as follows:

- 50% of first 8% of Eligible Earnings
- Maximum match is 4% if you contribute at least 8%
- Amounts contributed over 8% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 8% of Eligible Earnings for a total Employee contribution of $4,000 per year. The Company has a matching contribution of:

50% of the first 8% of Eligible Earnings:	$4,000 x 50% = $2,000
Company matching contribution:	$2,000

Metal Trades Council (MTC) – Hired On or After 1/1/2016

The Company provides MTC Employees hired on or after 1/1/2016 with matching contributions as follows:

- 100% of first 2% of Eligible Earnings

- 50% of next 4% of Eligible Earnings
- Maximum match is 4% if you contribute at least 6%
- Amounts contributed over 6% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 6% of Eligible Earnings for a total Employee contribution of $3,000 per year. The Company matching contribution would be:

100% of the first 2% of Eligible Earnings:	$1,000 x 100% = $1,000
50% of the next 4% of Eligible Earnings:	$2,000 x 50% = $1,000
Company matching contribution:	$2,000

Metal Trades Council (MTC) – Hired Before 1/1/2016

The Company provides MTC Employees hired before 1/1/2016 with a matching contribution as follows:

- 62.5% of first 8% of Eligible Earnings
- Maximum match is 5% if you contribute at least 8%
- Amounts contributed over 8% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 8% of Eligible Earnings for a total Employee contribution of $4,000 per year. The Company matching contribution would be:

62.5% of the first 8% of Eligible Earnings:	$4,000 x 62.5% = $2,500
Company matching contribution:	$2,500

Pantex Guards Union (PGU) – Hired before 3/18/2002 and Opted Out of the Pension Plan or Hired on or after 3/18/2002 (not eligible for the Pension Plan)

The Company provides PGU Employees who were either hired before 3/18/2002 and opted out of the Pension Plan in favor of an Enhanced 401(k) match, or were hired on or after 3/18/2002, with a matching contribution as follows:

- 100% of first 10% of Eligible Earnings
- Maximum match is 10% if you contribute at least 10%
- Amounts contributed over 10% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 10% of Eligible Earnings for a total Employee contribution of $5,000 per year. The Company matching contribution would be:

100% of the first 10% of Eligible Earnings:	$5,000 x 100% = $5,000
Company matching contribution:	$5,000

Pantex Guards Union (PGU) – Hired before 3/18/2002 and Opted to Remain in the Pension Plan

The Company provides PGU Employees hired before 3/18/2002 who opted to remain in the PGU Pension Plan with a matching contribution as follows:

- 50% of first 8% of Eligible Earnings
- Maximum match is 4% if you contribute at least 8%
- Amounts contributed over 8% are not eligible for Company matching contributions

Example

Employee with $50,000 of Eligible Earnings contributes 8% of Eligible Earnings for a total Employee contribution of $4,000 per year. The Company matching contribution would be:

50% of the first 8% of Eligible Earnings:	$4,000 x 50% = $2,000
Company matching contribution:	$2,000

Beginning 1/1/2008, PGU employees receive a $500 employer contribution with the first paycheck of each year. Such amounts contributed prior to 1/1/2023 were 100% vested when contributed. Such amounts contributed on and after 1/1/2023 are subject to the vesting schedule described below applicable to the Enhanced Defined Contribution Plan.

Enhanced Defined Contribution Program

Eligible Employees at Pantex will receive this contribution regardless of participation in the Savings Plan.

Pantex Non-Bargaining – Not Eligible or Not Vested in the Pantex Non-Bargaining Pension Plan

Pantex non-bargaining Employees who were not vested in the Pension Plan as of 2/20/2012 or who were hired on or after 2/20/2012 are eligible to receive an additional non-discretionary contribution under the 401(k) Savings Plan. This non-discretionary contribution is funded totally by the Company and is based upon years of service as follows:

- Less than 5 years of service – 3% of Eligible Earnings
- 5 years of service or more – 4% of Eligible Earnings

Note: Pantex Protective Force Officers are not eligible for the Enhanced Defined Contribution Plan.

MTC – Hired on or After 1/1/2016

Metal Trades Council (MTC) Employees hired on or after 1/1/2016 receive additional Employer contributions in their 401(k) (in lieu of pension benefits) as follows:

- Less than 5 years of service – 3% of Eligible Earnings
- 5 years of service or more – 4% of Eligible Earnings

Note: MTC Employees hired before 1/1/2016 are not eligible for the Enhanced Defined Contribution Plan.

Vesting

You are 100% vested in your own contributions and any rollover contributions as adjusted for investment earnings and losses. Company matching contributions and Enhanced Defined Employer Contributions are vested based on years of Credited Service (as defined in the Glossary) as follows:

401(k) Savings Plan Company Matching Contributions: Pantex

Pantex Non-Bargaining Employees Hired Before January 1, 2015	
Years of Credited Service	Percentage (%) Vested
Year 2	20%
Year 3	100%
Pantex Non-Bargaining Employees Hired On or After January 1, 2015	
Years of Credited Service	Percentage (%) Vested
Year 3	100%
MTC Employees Hired On or After January 1, 2016	
Years of Credited Service	Percentage (%) Vested
Year 3	100%
Pantex Protective Force Officers and PGU Employees	
Years of Credited Service	Percent (%) Vested
Year 2	20%
Year 3	40%
Year 4	60%
Year 5	80%
Year 6	100%

MTC Employees Hired Before January 1, 2016	
Years of Credited Service	Percent (%) Vested
Year 2	20%
Year 3	40%
Year 4	60%
Year 5	80%
Year 6	100%

Enhanced Defined Contributions

For Pantex Employees, the Enhanced Defined Contribution Plan employer contributions are vested as follows:

Pantex	
Years of Credited Service	Percentage (%) Vested
Year 2	20%
Year 3	40%
Year 4	60%
Year 5	80%
Year 6	100%

You will become 100% vested in all Company matching contributions and Enhanced Defined Contributions, adjusted for investment earnings and losses, when you:

- Reach age 65 (normal retirement age) while a Company Employee
- Retire and are eligible to receive an immediate Pension from the Pension Plan
- Leave the Company because you are Totally and Permanently Disabled, die, or are involuntarily terminated for reasons other than gross misconduct.

Investment Options

You may choose to have your contributions and the Company contributions invested in any one or a combination of the 401(k) Plan's investment funds in increments of 1%. The funds are valued each day the stock markets are open.

The Benefits and Investment Committee (the "Committee"), with the assistance of a professional investment consulting firm, reviews fund performance on a regular basis, as well as each fund's strategy and goals. Based on its review, the Committee may change investment fund offerings (including eliminating particular funds) at times. When this occurs, you will be notified. The Committee may freeze or change the funds at any time. The Committee has designated target date funds as the "Qualified Default Investment Alternative." If you do not direct the investment of your account, your account will automatically be invested in the target date fund closest to your 65th birthday.

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

You will be furnished information on a regular and periodic basis describing the various investment funds offered under the Plan. This information will describe and compare the various funds available. It will also describe such items as fees or similar charges under the fund and the mechanics of directing Plan investments. Fund information is available from the website, including copies of the most recent prospectuses and financial statements of the investment funds.

Neither the Company, the 401(k) Plan, nor the Committee makes any representation that the past performance of these funds is a guarantee or indicative of their future performance. The funds are not protected by any federal or state deposit insurance plan. The 401(k) Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA). Fiduciaries may be relieved of liability for any losses that are the result of investment instructions given by you or your Beneficiary.

Investment Earnings

Investment earnings include interest, dividends, and market gains/losses resulting from your investments in any of the 401(k) Plan's funds. Returns you may earn on your investments are continually reinvested in the funds you have chosen.

Changing Your Investments

You may change your investment choice for future contributions – in 1% increments – at any time by:

- Calling Participant Services
- Accessing your online account

The last change you make before 3:00 p.m. central time, 4:00 p.m. eastern time, or before the market closes if earlier, will override any previous changes made that day. Your changes will be effective with the next deposit of your contributions.

You can also transfer existing balances among the investment options. Transfers completed before 3:00 p.m. central time, 4:00 p.m. eastern time, will be effective that day, assuming it is a business day and the New York Stock Exchange is open. Otherwise, changes will be effective the next business and market trading day. Confirmation of your transaction will be mailed within three business days.

Transaction Processing

The transactions you request will ordinarily be processed within the times specified in this SPD. However, in certain circumstances, such as technical problems with the website or telephone service, you may experience difficulty in making your request or your transaction may be delayed.

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

Reward vs. Risk

One way to think of the gain or loss potential of an investment is to think of the potential for reward or the level of risk it offers. Generally, investments with more risk to principal have the potential to yield higher returns over a longer period of time than investments with less risk. No one can tell you what balance of reward vs. risk is right for you. It is up to you to decide. When making your decision, ask yourself the following questions:

- **When will you need the money in your accounts?**

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

- **What are your investment goals?**

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

- **What is your financial situation?**

Figure out how much money you can afford to save. It may be more than you think. If you save a small amount on a before-tax basis, with the tax savings you receive from before-tax contributions, your take-home pay may not be reduced as much as you expect.

- **Are your investments sufficiently diversified?**

Investment professionals seek to reduce risk by diversifying their investments – not putting too many eggs in one basket. They may diversify over different types of investments, such as stocks and bonds, and within types of investments by buying stocks and bonds of a number of different companies. Since most of the funds offered under the 401(k) Plan are made up of several different investments, there is a basic level of diversification within most funds. However, you can further diversify by investing in funds to take advantage of the different investment objectives and strategies offered by the funds. If you invest in the target date funds, they are diversified and take into account when you will reach normal retirement age.

Loans from Your Account

Although the 401(k) Plan is meant to help you save for the future, you have some access to your funds today through loans and withdrawals.

You may borrow money from a portion of your vested account balance and pay back the loan through payroll deduction. You will repay loan amounts, plus interest, back to your 401(k) Plan account. You will not be taxed on the money you borrow from your account, provided you repay the loan as required, and any interest that you pay is credited to your account. Loan payments are made on an after-tax basis.

There are two types of loans available to Employees—general and residential. General loans are available for any reason. Residential loans are for the purchase or building of your primary residence. You may only have one general loan and one residential loan outstanding at any one time. There is a 30-day waiting period between loan payoff and getting a new loan.

Taking a Loan

For a general loan:

- Log on to your account or call Participant Services to find out the maximum loan amount available to you and current interest rates.
- Select the loan amount and terms that best suit your needs.

You will be mailed a check and loan disclosure statement to your address on record, generally within three business days. The check and loan disclosure statement constitute your legal notification of your loan responsibilities. Your endorsement indicates your acceptance of those responsibilities and your promise to repay the loan within the agreed-upon period.

For a residential loan:

- Log on to your account or call Participant Services to request a residential loan package, which will include a promissory note.
- Sign and return the application along with any other paperwork to the Recordkeeper within 60 days of the date on the note.

You will be mailed a check and loan disclosure statement, generally within three business days after your loan is approved. The check and the loan disclosure statement constitute your legal notification of your loan responsibilities and your promise to repay the loan within the agreed-upon period.

Loan Amounts

The maximum amount available for loans at any one time is the lesser of:

- 50% of your vested account balance at the time of the loan
- $50,000 minus your highest outstanding loan balance during the previous 12 months

Maximum total amount of all loans may not exceed $50,000 in a 12-month period.

Your account balance is based on the market value of the funds at the time the loan is requested. The minimum loan amount is $1,000.

For information about the maximum loan amount available to you, check your account online or call the appropriate Recordkeeper.

Loan Fee

There is a one-time, non-refundable loan origination fee of $75 for each loan. This fee will be deducted from your account balance on a pro-rata basis from your investment funds after the loan has been granted.

Interest Rate

The loan interest rate used for the entire term of the loan is the Reuters Prime Rate plus 1%, as published in The Wall Street Journal on the first business day of the month preceding the month in which the loan is requested. The rate in effect when you take a loan is the rate you will pay for the term of your loan. Under current federal income tax law, none of the interest on a loan from the 401(k) Plan is tax-deductible.

Loan Funding

If your loan is approved, a loan account is set up in your name. The loan amount is taken pro-rata from all Participant funds and all sources based on the balance in that fund/source to the total balance in the Participant's account.

Paying Your Loan

Loan payments will be automatically deducted from your paychecks. General loans must be paid within 5 years; residential loans must be paid within 15 years. The minimum loan payment period is six months.

As you pay your loan, your savings will be restored in the reverse order from which your loan was taken. At the time each payment is made, balances will be restored proportionally in the 401(k) Plan investment funds you have chosen for your current contributions.

- At Pantex, your savings will be restored on a pro-rata basis to all sources.
- If you notice that payments are not being deducted from your paycheck as expected, it is your responsibility to contact the Pantex Benefits Office to determine why those payments are not being deducted. Failure to make timely payments will cause the loan to go into default.

You may pay off your outstanding loan at any time by sending a certified check to the Recordkeeper for the payoff amount. The outstanding balance must be paid off in full; no partial payments are allowed. You must contact the Recordkeeper to find out payoff amounts.

Any payments missed because of a short-term absence may be automatically deducted from your paycheck when you return to work.

If you take an unpaid leave of absence or are on Long-Term Disability, you must continue to make payments directly to the Recordkeeper. Any missed payments during your absence may be re-amortized upon your return to work.

Loan Default

A portion of your account balance, equal to the amount of your original loan, serves as collateral for the loan. If you default on your loan, the Recordkeeper will satisfy your unpaid loan balance by using the collateral in your account. Your loan will default if you:

- Leave the Company and do not pay the outstanding balance within six months
- Fail to make a scheduled loan payment by the end of the quarter following your last payment
- Do not pay your loan by the end of the term of the loan
- Are on an unpaid leave of absence or Long-Term Disability and stop making payments.

The first loan default warning will be sent when a loan payment is not received within 30 days of the next payment date. The second warning will be sent 60 days after the expected payment date. Loans are considered in default if payment is not received by the end of the quarter following the quarter in which the payment should have been received.

If your loan defaults, the outstanding balance of your loan will be treated as a taxable distribution. Your defaulted loan will be subject to tax law distribution rules such as a 10% penalty if you are under age $59^1/_2$ and are not disabled. The amount payable to you from the 401(k) Plan will be reduced by the outstanding balance on the loan.

You may not take out a new loan while you have a loan that is in the default process.

Change in Payroll Frequency

If your payroll frequency changes from weekly to bi-weekly or vice versa, the payment of the remaining principal loan balance will be re-amortized for the new payroll frequency. Please contact the Pantex Benefits Office to ensure the appropriate loan payment amount is deducted each pay period.

Withdrawals While You Are Employed

The 401(k) Plan allows you to take a withdrawal from your account while you are still employed by the Company within certain limits and rules, which are described in this section. You will be mailed a check generally within three business days after your withdrawal is approved.

Withdrawal of Before-Tax and Roth Contributions

It is important to remember that withdrawals of your before-tax contributions are restricted by the Internal Revenue Code while you are working. Roth contributions are generally treated like before-tax contributions for withdrawal limitations. You may not withdraw your before-tax or Roth contributions before you reach age $59^1/_2$ unless you have a hardship as discussed below. You must include withdrawals of before-tax contributions in your income in the year of withdrawal. In some cases, distributions of before-tax and Roth contributions may also be subject to a 10% premature withdrawal tax penalty, so consider these tax implications before making a withdrawal of your before-tax or Roth contributions.

Hardship Withdrawals before Age $59^1/_2$

Because the emphasis is on long-term savings, the government limits withdrawals of your before-tax and Roth contributions before age $59^1/_2$ to financial hardship situations.

To qualify for a hardship withdrawal, you must have a documented “immediate and heavy financial need” that cannot be met by “other reasonably available resources.” Hardship withdrawals are allowed under the IRS guidelines as follows:

- Purchase of your primary residence (but not mortgage payments)
- Tuition payments for a year of post-secondary education for you, your Spouse, or Dependent Child(ren); the amount may also include room and board expenses for the year

- Expenses not covered by insurance for you, your Spouse, or Dependent Child(ren) that would qualify as deductible medical expenses (not taking into account income limitations)
- Expenses to prevent eviction from or foreclosure on your primary residence
- Funeral expenses of your deceased parent, Spouse, Child, or dependent
- Expenses for repair of damage to your principal residence that would qualify as deductible casualty expenses (not taking into account income limitations)
- Expenses and losses (including loss of income) you incur on account of a disaster declared by the Federal Emergency Management Agency ("FEMA") under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100-707, provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster

"Other reasonably available resources" include 401(k) Plan amounts. You must request a maximum withdrawal of any amounts available for withdrawal before you request a hardship withdrawal. You must also provide a representation in writing that you have insufficient cash or other liquid assets reasonably available to satisfy the need.

Withdrawals are also available from the vested portions of your Company contributions and earnings thereon in the case of financial hardship before amounts are withdrawn from your before-tax and Roth contributions. Rollovers to both Plans and earnings thereon are also available for withdrawal. Therefore, you must also take a withdrawal from these accounts prior to any withdrawal of before-tax and Roth contributions.

Hardship withdrawals are not eligible to be rolled over to another qualified plan or IRA.

You may log on to your account or contact the Recordkeeper for a hardship withdrawal request form. Hardship withdrawals must be approved by the Recordkeeper.

Withdrawals after Age 59$^{1}/_{2}$

When you reach age 59$^{1}/_{2}$, you may withdraw your before-tax contributions, Roth, vested Company matching contributions, enhanced Employer contributions, and any investment earnings at any time for any reason. These withdrawals are limited to once per quarter at Pantex.

Withdrawal during Military Leave

You may be able to withdraw your before-tax or Roth contributions if you go on military leave for more than 30 days. If you think this applies to you, contact Participant Services. If you take a withdrawal of before-tax or Roth contributions while you are on military leave, you may not make contributions to the 401(k) Plan for six months after the withdrawal.

To request a withdrawal, log on to your account or call Participant Services.

Withdrawal of Rollover Contributions

You may withdraw your rollover contributions, as adjusted for investment earnings and losses, at any time for any reason without causing a suspension of Company contributions under the 401(k) Plan. To request a withdrawal, log on to your account or contact the Recordkeeper.

Plan Payouts

You are eligible to receive the full vested value of your 401(k) Plan account when you leave the Company, and:

- Reach normal retirement age (age 65),
- Are Totally and Permanently Disabled, or
- Are an Alternate Payee under a Qualified Domestic Relations Order.

If you voluntarily resign (or are discharged for cause) before achieving 100% vesting, you will forfeit any Company matching contributions and Enhanced Defined Contributions in which you are not vested, adjusted for investment gains and losses.

Forfeitures will be used for corrective allocations, contributions, plan expenses, restorations if permitted by law or administrative guidance, to reduce matching contributions due from the participating employers for such Plan year, and for such purposes in succeeding Plan years.

Timing of Payouts

When you leave the Company, you may request an immediate payout or choose to defer payment. If you choose to defer payment, your savings will be invested in the 401(k) Plan funds you direct.

Mandatory Distributions

Under IRS required minimum distribution rules, you may not defer payment beyond April 1st of the year following the year in which you reach your required beginning age or the date you retire if you work for the Company beyond your required beginning age. Your required beginning age is age $70^1/_2$ if you turned age $70^1/_2$ before January 1, 2020, or age 72 if you turned age 72 before January 1, 2023. Otherwise, your required beginning age is age 73. Your Roth contributions and earnings are also subject to this rule unless you roll over the Roth account into a Roth IRA.

If your vested account balance is less than $1,000 when you leave the Company and you do not request a payout method or rollover, your entire vested account balance, including your rollover amount, will be distributed to you in a single lump sum payment.

If your vested account balance is between $1,000 and $5,000 when you leave the Company and you do not request a payout method or rollover, your entire vested account balance, including your rollover amount, will automatically be rolled into an Individual Retirement Account (IRA) managed by the Recordkeeper.

Payout Method

The following payout options are available under the Pantex Plan:

- A lump sum payment of your entire vested interest.
- A partial payment.
- Monthly installment payments of a fixed period of 10, 15, or 20 years (as long as this method meets the IRS minimum distributions requirements), with monthly recalculations based on market value and the remaining payment period.
- Monthly installment payments over a period equal to your life expectancy or the joint life expectancy of you and your Spouse (as long as your Spouse is your designated Beneficiary).
- A fixed dollar installment amount that you choose. You may change the fixed amount at any time.

If you elect installments over your life expectancy, the number of monthly installments will be determined using the uniform life expectancy table with monthly recalculations based on market value

and the remaining payment period. Life expectancies are recalculated each year. You will also have the option of requesting a total distribution from your Roth account.

If you have not commenced payment upon death, your account balance will be distributed to your Beneficiary in a lump sum unless your Beneficiary elects to receive installments over a five-year period. If you had begun payments, the remainder of your account will be distributed to your Beneficiary in a lump sum unless you were receiving payments over the joint life expectancy of you and your Spouse. In that case, the remaining amount will be paid in installments over the Spouse's life expectancy.

Electing a Payout

If you leave the Company, the Recordkeeper will send a letter to you describing your payout options.

You may make your payout election over the telephone.

Request a Payout

To apply for a 401(k) Plan payout, call Participant Services. If you elect a lump sum payout, you will be mailed the payout generally within three business days from the date Participant Services receives the request.

If you die with a remaining balance in the Plan, your Beneficiary(ies) should contact the Recordkeeper for information on obtaining a distribution.

Taxation of Withdrawals and Final Payouts

In general, your before-tax contributions, Company matching contributions, Enhanced Defined Contributions, and investment earnings on all types of contributions, other than Roth contributions, are taxable when you receive them. The actual tax treatment will depend on your age at the time of receipt. Additional information about tax treatment of 401(k) Plan distributions can be found in the "Special Tax Information Notice" section. Information is also available online or by calling Participant Services.

Distributions or Withdrawals before Age $59^1/_2$

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

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

Distributions or Withdrawals at Age $59^1/_2$ or Later

If you make a withdrawal or receive a 401(k) Plan distribution after age $59^1/_2$, you will not have to pay the 10% penalty; however, you will be responsible for the payment of any taxes due.

Roth Contributions

Special rules apply to payments of Roth contributions and earnings on those contributions. Payments of the Roth contributions are not subject to federal income tax because the contributions were made on an after-tax basis. Earnings on your Roth contributions will be subject to federal income tax unless the distribution occurs at least five years after you made your first Roth contribution or roll over Roth contributions from a former employer and the distribution is made after you turn $59^1/_2$, upon your death, or upon your disability. Employer match contributions and earnings on Roth contributions are taxable upon distribution.

Rollovers and Withholding

Withdrawals and lump sum distributions of your before-tax contributions, Roth contributions, Enhanced Defined Contributions, and Company matching contributions, as adjusted for investment earnings and

losses, can be rolled over to an IRA, a Roth IRA, or other eligible retirement plan. Required minimum distributions to Employees who have terminated and reached age $70^1/_2$ or retired from the Company after age $70^1/_2$ are not eligible for such a rollover.

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

If you want to roll over your eligible distribution yourself – an indirect rollover – there are some important facts to keep in mind:

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

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

To ensure you are using your benefits to their full advantage, check with a tax advisor regarding the specific requirements for using these and other forms of favorable tax treatments that may apply to your distribution. Neither the Pantex Benefits Office nor Participant Services can provide tax advice.

Severance from Service and Re-Employment

Severance from service is important because it determines when your Credited Service ends for purposes of 401(k) Plan vesting. Severance from service occurs:

- The day you quit, retire, are discharged, or die.
- One year after your first day of absence due to layoff, or, if earlier, the first day after recall if you fail to return to work.
- One year after your first day of leave of absence, or, if earlier, the first day after the final day of leave if you fail to return to work.
- Two years after your first day of absence for a parental leave due to pregnancy, birth, or adoption, and for child care immediately following the birth or adoption or, if earlier, the first day after the final day of leave if you fail to return to work.

If you are re-employed within one year of your date of severance, you will receive Credited Service for your period of severance and your prior Credited Service will be restored.

If you are re-employed more than one year after your date of severance and you had any vested interest in any account in the Pantex Plan on your date of severance, your prior Credited Service will automatically be restored upon re-employment, regardless of your period of severance.

Pantex may grant Credited Service for any time previously worked for rehired non-bargaining employees.

Other Important Information

Change of Address

It is important to notify the Company of any change in address while you are a Participant in the 401(k) Plan to ensure you receive Company communications about the 401(k) Plan. If you are retired, contact Pantex Benefits Office.

Voting Your Shares

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

Investment Fees and Expenses

In addition to considering risk and return, time, diversification, and your other savings vehicles, you may also want to consider that some of the funds may have accompanying investment management fees besides redemption fees. For example, fund and management expenses for a particular fund may be charged against your investment returns. The fees may, in effect, reduce your actual investment return. For more information about the fees, contact the Recordkeeper.

The 401(k) Plan incurs administrative fees including recordkeeping, accounting, trustee functions, and legal services. The administrative fees may be charged to participant accounts or paid by the Company. More information about the fees is included in the annual fee disclosure statement distributed by the Plan Recordkeeper to Participants. Fees for items directly related to your account, such as loan processing, hardship withdrawal processing, or domestic relations order processing may be charged to your account. Administrative fees will be shown on your quarterly statement or the Plan website.

✆ Call Participant Services or use the Internet for:

- **Financial information** – prospectuses and fund fact sheets, to the extent they are available and provided to the 401(k) Plan
- **Investment performance** – past and current investment performance of each fund as it becomes available
- **Account value** – value of each investment fund within your personal account

Responsibility for Investment Decisions

You choose how to invest your money in the 401(k) Plan. The 401(k) Plan trustee will follow your directions without reviewing your investment decisions.

The Company, the trustee, the Committee, and the other 401(k) Plan Administrators are not responsible or liable for the investment choices you make or investment losses that are the direct and necessary result of your investment choices. This is because the 401(k) Plan is intended to satisfy the requirements of Section 404(c) of ERISA and Section 2550.404c-1 of the Code of Federal Regulations. Nothing contained in this document is intended to constitute investment advice.

Confidentiality of Investment Directions

Your investment directions for all 401(k) Plan funds are administered by the Recordkeeper. The trustee handles all purchases and sales in the name of the 401(k) Plan without identifying individuals, so your transactions remain confidential.

The Committee is responsible for monitoring compliance with the procedures that ensure confidentiality. You may contact the Committee at:

Benefits and Investment Committee
PanTeXas Deterrence, LLC
P.O. Box 30020
Amarillo, TX 79120-0020

Other Benefits

Before-tax savings under the 401(k) Plan reduce your taxable income – that is, they are not reported as taxable income on your W-2 earnings statement. However, they are included in determining your Social Security taxes and benefits.

Savings with before-tax dollars have no effect on your other pay-related benefits – such as Life Insurance, disability coverage, and retirement income. These benefits provide financial protection and security based on your basic rate of pay.

Plan Funding and Investment Management Fees

The 401(k) Plan is funded by Participants who designate a part of their Eligible Earnings to be contributed on their behalf and by the Company through Company matching contributions and Enhanced Defined Contributions. The assets of the 401(k) Plan are held in a trust fund maintained by the trustee. All 401(k) Plan investment management fees are paid from the investment funds and will be deducted from Participants' account(s).

Tax Treatment

The Company intends to operate the 401(k) Plan so it will qualify under Sections 401(a) and 401(k) of the Internal Revenue Code. Accordingly, your before-tax savings will not be taxed until you withdraw them. Your Roth contributions are taxed prior to the contribution to the 401(k) Plan. The earnings of the trust fund, which holds the 401(k) Plan assets, will not be taxable to you, the trust fund, or to the Company at the time earnings are credited to the trust fund. Earnings may be taxable to you when you receive a distribution. However, earnings on Roth contributions will not be taxable either in the trust fund or when distributed if you meet IRS requirements. Amounts rolled over to a Roth IRA may be taxable to you at the time of the rollover if they were not already held in the Plan as Roth contributions.

Termination or Amendment of the Plan

The Company reserves the right to terminate the Plan in its entirety or for any group of eligible Participants, as well as to amend the Plan, but such termination or amendment of the Plan shall require the approval of the Company's Board of Managers or authorized delegate.

The substitution of a successor contractor by the U.S. Department of Energy for a participating employer will not be treated as a termination or partial termination of the Plan. Upon complete or partial termination or a complete discontinuance of contributions, the accounts of all Participants will be fully vested to the extent not already fully vested. The amendment or termination of the Plan will not cause or permit any part of the trust fund to be diverted to purposes other than for the exclusive benefit of the Participants, or cause or permit any portion of the trust fund to revert to or become the property of the Company at any time prior to the satisfaction of all liabilities with respect to the Participants and Beneficiary(ies).

Upon termination of this Plan, the Plan Administrator will continue to act for the purpose of complying with the preceding paragraph and will have all power necessary or convenient to the termination and dissolution of the Plan.

Pension Benefit Guaranty Corporation

The Plan is a defined contribution plan, providing contributions to you in specific amounts with your vested Plan account value payable to you when you leave or retire. Defined contribution plans are not eligible to be insured by the Pension Benefit Guaranty Corporation (PBGC).

Rights of Participants and Beneficiaries under ERISA

ꝺ Under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, you have the following rights:

Receive Information about Your Plan Benefits

- You may examine, without charge, all documents that describe the Plan. These documents may include Summary Plan Descriptions, Summaries of Material Modifications, other Employee communications relating to the Plan, the latest annual report (Form 5500 Series), and other official Plan documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration at:

  Public Disclosure Room
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, NW, Room N 15
  Washington, DC 20210

- The Plan Administrator makes these documents available for examination, free of charge, at specified sites, such as Company work locations. For information, write to the Plan Administrator at:

  Benefits and Investment Committee
  PanTeXas Deterrence, LLC
  P.O. Box 30020
  Amarillo, TX 79120-0020

- You may also obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator at the above address. Please include the full name of the Plan in your written request, along with your name, mailing address, and telephone number. You may be charged a small copying fee per page for documents that you request.
- Additionally, you may receive a summary of the Plan's annual financial report. The Plan Administrator is required, by law, to furnish you with a copy of this Summary Annual Report.
- For questions about Plan benefits or requests for Summary Plan Descriptions, Summaries of Material Modifications, or other Plan-related communications, call 1-806-573-1100 or write to:

  Benefits and Investment Committee
  PanTeXas Deterrence, LLC
  P.O. Box 30020
  Amarillo, TX 79120-0020

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. The persons who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiary(ies).
- No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done and to obtain copies of documents relating to the decision without charge.
- You have the right to have your claim reviewed and reconsidered on appeal, but your appeal must be timely. Under ERISA, there are steps you can take to enforce the above rights.
- For instance, if you request materials from the Plan Administrator that you have a right to receive 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted all administrative remedies. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court after you have exhausted all administrative remedies. 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 to be frivolous).

Time Limits and Lawsuits

When you make a claim for benefits, you must notify the Plan Administrator. The Plan Administrator provides you with a copy of the form that must be completed in order to process your claim for benefits.

After your claim for benefits is processed, you must notify the Plan Administrator in writing, if you have questions or disagree with the calculation of your benefit or other decision regarding your claim. The Plan Administrator will, within 90 days (or within 180 days if special circumstances exist), notify you in writing of its decision.

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. That notification will include:

- How your benefit was calculated
- The specific reason your claim was denied (in whole or in part) if it is denied
- Specific references to Plan provisions on which the denial is based
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such information is necessary
- An explanation of the Plan's claim review procedures

Within 60 days after you receive notice of the denial of part or your entire claim for benefits, you may file a written appeal with the Benefits Appeals Committee, which will review the original determination, the Plan document, and the information you submit supporting your appeal. You may seek representation by an attorney to assist in your appeal. You may submit written or oral evidence of your claim. You may review all documents relevant to your claim. The Benefits Appeals Committee generally makes a final decision within 60 days of your appeal, but special circumstances may require additional time up to another 60 days.

The Benefits Appeals Committee will include the specific reasons for its decision and specific references to Plan provisions on which the determination was made. If you are not satisfied with the decision and have exhausted all administrative remedies, then you may file a lawsuit in federal court. The suit must be filed within one year of the date of the final decision on your appeal by the Benefits Appeals Committee.

Assistance with Your Questions

- If you have any questions about the Plan, contact Pantex Benefits Office at 1-806-573-1100. The Plan Administrator has established this service for purposes of administering benefits and responding to Participant and Beneficiary questions. 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, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or write to:

  Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, NW
  Washington, DC 20210

- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Administrative Information

Plan Administrative Information at Pantex – Bargaining Unit

Plan Administrative Information at Pantex	
Plan Name	PanTeXas Deterrence 401(k) Plan for Bargaining Pantex Location Employees
Plan Number	012
Plan Year	The records of the Plan are kept on a calendar year basis (January 1 through December 31)
Effective Date of this SPD	November 1, 2024
Plan Administrator	Benefits and Investment Committee PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020
For Appeals	Benefits Appeals Committee c/o PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020
Plan Sponsor & Employer Identification Number	PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020 EIN: 92-3671850
Agent for Service of Legal Process	CT Corporation System 1999 Bryan Street Suite 900 Dallas, Texas 75201-3136 Legal process may also be served upon the Plan Trustee or the Plan Administrator.
Plan Type	A defined contribution plan (a 401(k) plan) subject to the provisions of ERISA
Third-Party Administrator	Payment of benefits and the non-discretionary administration of investment direction, enrollment and participant questions and requests have been delegated to the Recordkeeper
Recordkeeper Information	Voya Financial P.O. Box 55772 Boston, MA 02205-5772

Plan Administrative Information at Pantex – Non-Bargaining

Plan Administrative Information at Pantex	
Plan Name	PanTeXas Deterrence, LLC 401(k) Plan for Non-Bargaining Pantex Location Employees
Plan Number	013
Plan Year	The records of the Plan are kept on a calendar year basis (January 1 through December 31)
Effective Date of this SPD	November 1, 2024
Plan Administrator	Benefits and Investment Committee PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020
For Appeals	Benefits Appeals Committee c/o PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020
Plan Sponsor & Employer Identification	PanTeXas Deterrence, LLC P.O. Box 30020 Amarillo, TX 79120-0020 EIN: 92-3671850
Agent for Service of Legal Process	CT Corporation System 1999 Bryan Street Suite 900 Dallas, Texas 75201-3136 Legal process may also be served upon the Plan Trustee or the Plan Administrator.
Plan Type	A defined contribution plan (a 401(k) plan) subject to the provisions of ERISA
Third-Party Administrator	Payment of benefits and the non-discretionary administration of investment direction, enrollment and participant questions and requests have been delegated to the Recordkeeper
Recordkeeper Information	Voya Financial P.O. Box 55772 Boston, MA 02205-5772

Official Plan Document

This SPD describes the main provisions of the Plan, but not every detail is included. Your rights and benefits are governed solely by the official Plan Documents. It is important, therefore, to ask questions and get clarification on any matters about which you are uncertain. If there is ever a conflict between this SPD and the Plan Document, the Plan Document will govern.

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Severance Plan

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Severance Pay is money paid by the Company to some Employees whose employment ends involuntarily.

The Severance Plan:

The PanTeXas Deterrence, LLC Severance Plan (the "Plan") for Non-Bargaining Unit Employees provides severance pay benefits to eligible non-bargaining unit Employees of the Company. The Company maintains the Plan as a means of providing eligible Employees with severance pay in the event their employment ends involuntarily in certain circumstances and in recognition of their years of service with the Company.

This document describes the Plan benefits as they apply to eligible Employees and serves as the summary plan description (SPD) for the Plan under the Employee Retirement Income Security Act of 1974 (ERISA). This SPD is not a substitute for the actual Plan document. The Plan Document remains the final authority on the Plan's terms; in the event of a conflict with this SPD, the Plan Document will control in all cases.

You may review the official plan document upon request at the Plan Administrator's office at a reasonable time. Upon written request, the Plan Administrator will give you a copy of the Plan Document. The Plan Administrator may impose a reasonable charge for copying the Plan.

You should read this SPD carefully. Certain capitalized words have special meanings and are defined elsewhere in this SPD. If you have questions about the Plan or this SPD, contact the Plan Administrator. The Plan Administrator's contact information is located at the end of this SPD.

The Company reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time at its discretion with or without advance notice to participants, for any reason, subject to applicable law.

Eligibility

Who Is Eligible?

To be eligible for severance pay benefits provided under this Plan, you must be categorized and paid by the Company as a regular non-bargaining unit Employee of the Company and your employment with the Company must be involuntarily terminated in a reduction in force. This means that the Company must initiate the termination, and the Company's payroll records must reflect that you were terminated as part of a reduction in force.

To be eligible for participation in the Plan, you must also receive a Notification Letter from an authorized Company official immediately before or at the time of your termination of employment. The Notification Letter must indicate your anticipated Termination Date and must state that you are eligible for severance benefits.

Even if you receive this Notification Letter, you will not be eligible to receive severance benefits unless you satisfy all of the conditions for receiving a benefit under this Plan, including execution of a General Release and Waiver. These conditions are discussed below.

If you do not receive a Notification Letter, you will not be eligible to receive severance benefits under this Plan.

Who Is Not Eligible?

If you do not meet all of the Plan's eligibility requirements, including the Plan's conditions for receipt of a severance benefit, you will not be entitled to any severance pay when you terminate employment with the Company.

You are not eligible to receive severance pay and may not participate in the Plan if you are any one of the following:

- You are employed in a temporary position, as determined by the Company;
- You are categorized by the Company as a bargaining unit Employee;
- You have less than one year of Company Service (this term is defined in the Glossary);
- You are paid as an independent contractor or you are a leased employee;
- Your employment with the Company is terminated due to your death;
- You terminate your employment voluntarily or you initiate your termination of employment;
- You are terminated for Cause (this term is defined later in this section);
- You have an outstanding debt owed to the Company, unless you agree in writing that the Company may withhold the total amount of the outstanding debt from the severance payment to you;
- Your employment is terminated due to a temporary suspension of work;
- At the time you receive a Notification Letter, you are designated as in a Key Personnel position in the contract between the Company and the National Nuclear Security Administration (NNSA), you are an officer of the Company, or you are the facility security officer of the Company;
- You are employed by or receive an offer of employment with a contractor awarded a contract by the U.S. Department of Energy (DOE) or the NNSA for the management and operation of the Pantex Plant, or any portion thereof;
- You are employed by, or receive an offer of employment with, an affiliated employer;
- You do not execute a General Release and Waiver; or
- You signed a waiver of benefits, whether or not the waiver was executed before or in connection with your termination of employment.

If you do not meet the Plan's eligibility criteria, you will not be entitled to any severance pay or similar benefits upon termination of employment.

The Plan Administrator has the absolute and exclusive discretionary right and final authority to make any necessary determinations concerning whether an Employee is eligible to receive benefits under the Plan. Any determination by the Plan Administrator shall be final and binding on all parties.

Severance Benefits

How the Plan Works

If you meet the eligibility requirements to participate in the Plan and you satisfy all of the conditions for payment of benefits, you will receive severance pay benefits based on your Company Service and pay at your Base Rate in effect on the date immediately preceding your Termination Date.

How Are Severance Benefits Calculated?

Severance benefits are calculated as follows:

Company Service	Severance Pay at Base Rate
One full year or greater	Severance equal to 1 week of Pay for each full year of Company Service up to 26 weeks
Total Maximum Benefits	26 weeks of Pay

The Company may change your Termination Date (making it earlier or later) if the Company determines that the circumstances require a change.

How Are Severance Benefits Paid?

Severance pay benefits will be paid in a lump sum as soon as administratively possible within 60 days following your Termination Date, providing you satisfy all of the conditions for payment of severance benefits. This includes signing (and not revoking within the revocation period) a General Release and Waiver. Deductions will be made for taxes and all other required or authorized deductions.

If you are rehired by the Company, an affiliated employer, or a successor contractor before the end of the period covered by the severance benefits, you must return to the Company the severance pay for the period following your rehire date before you begin to work again. For example, if you received 20 weeks of severance benefits in a lump sum and you are re-employed after 15 weeks, you must return to the Company 5 weeks of Pay.

Conditions for Payment of Severance Benefits

If you receive a Notification Letter, you will not be eligible to receive a severance benefit under the Plan unless you satisfy each of the following conditions:

- You must sign a termination statement provided by the Company.
- You must return all Company property that is in your possession, custody, or control. This "property" includes, but is not limited to, all materials, documents, plans, records or papers, or any copies of such documents which, in any way, relate to the Company's affairs. This property further includes all tools, vehicles, cards, manuals, and any money due the Company.
- You must sign a General Release and Waiver of all legal or contractual claims of any kind (with some exceptions as more fully explained in the Waiver) in a timely manner and deliver it to the Company as directed.
- You must agree in writing to allow the Company to withhold from your severance benefit the amount of any outstanding debt you owe the Company.

Important Terms Relating to Severance Benefits

This SPD uses certain terms to describe the Plan and the severance benefits that are provided to eligible Employees. Some of these terms are defined below. If you have any questions about a particular term and how it may apply to you, contact the Plan Administrator.

Base Rate

Your regular straight-time pay for your normal work schedule for your last regular pay period with the Company immediately preceding your Termination Date. Base Rate excludes overtime pay, bonuses, commissions, fees, incentive allowances, certification pay, pay premiums for participation in the Human Reliability Program or work in the Material Access Area, and all employer-provided benefits.

Cause

Your termination of employment by the Company for reasons which include, but are not limited to, poor performance, misconduct, commission by you of any felony or misdemeanor involving moral turpitude under applicable law, or a violation of or a failure to follow the Company's rules or policies, all as determined by the Company.

Company Service

For purposes of this Plan only, the continuous period or sum of continuous periods of employment with the Company.

- If you are a Company Employee who was employed by Babcock & Wilcox Pantex, LLC as of June 30, 2014, "Company Service" will include your continuous service with Babcock & Wilcox Pantex, LLC, as well as any continuous service with Mason & Hanger Co., Inc.
- If you are a Company Employee who was employed by Consolidated Nuclear Security, LLC as of October 31, 2024, "Company Service" will include your continuous service with Consolidated Nuclear Security, LLC.

Your Company Service for purposes of the Plan will be determined as of your Termination Date under the Company's service rules. If you are or have been rehired, you will not receive any Company Service under the Plan for any period of service for which a severance benefit, layoff allowance, or similar payment previously paid to you by the Company or by any DOE or NNSA cost-reimbursement contractor.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder.

Key Personnel

Any individual listed in Section J, Appendix F of the contract between the Company and the NNSA, and any officer of the Company, including the facility security officer.

Notification Letter

Any formal notice from the Company that your employment with the Company will be involuntarily terminated.

Termination Date

The date designated by the Company as your last day of active employment.

Additional Rules that Apply to the Plan

Procedures for Filing and Appealing Claims

If a dispute arises concerning whether you are entitled to benefits under this Plan or as to the amount of your benefits, you must first file a claim for benefits in accordance with the following procedure. A claim for Plan benefits must be in writing and addressed to the Plan Administrator, c/o Director, Employee Benefits, at PanTeXas Deterrence, LLC, P.O. Box 30020, Amarillo, TX 79120-0020. In the event of a dispute, your claim for benefits must be received by the Plan Administrator within 6 months after your Termination Date.

You may file claims for Plan benefits and appeal adverse claim decisions yourself or through an authorized representative. An "Authorized Representative" means a person you authorize, in writing, to act on your behalf. You must follow the Plan's procedures for appointing an Authorized Representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. For additional information, contact the Plan Administrator.

You will be notified of the Plan's determination regarding your claim no later than 90 days after the Plan's receipt of the claim. This time period may be extended up to an additional 90 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 90-day period.

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

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

To have your claim reconsidered, you must file an appeal of an adverse benefit determination for a claim with the PXD Benefits Appeals Committee. The appeal must be submitted in writing to the attention of the Plan Administrator at P.O. Box 30020, Amarillo, TX 79120-0020. You will have 60 days following the receipt of an adverse benefit decision to appeal the decision. If you do not file an appeal, the initial decision will be deemed the final decision for time-limit purposes.

Ordinarily, you will be notified of the decision no later than 60 days after the appeal is received. If special circumstances require an extension of time of up to an additional 60 days, you will be notified of the extension during the 60 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

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

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

- The reasons for the decision, again with reference to the specific Plan provisions on which that decision is based;

- Notice that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits; and
- Notice of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review.

Exhaustion of Administrative Remedies and Limitations on Actions

You must use and fully exhaust all of your actual or potential rights under the Administrative Claims and Appeals Procedures for this Plan by timely filing an initial claim and then seeking a timely appeal of any denial before filing suit. The exhaustion requirement relates to claims for benefits, eligibility, and to any other issue, matter, or dispute (including any Plan interpretation or amendment issue).

Any such suit must be filed within one year after receiving a Final Adverse Benefit Determination on appeal. Failure to follow the Administrative Claims and Appeals Procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.

Assignment of Benefits

Any rights and/or benefits that you may have under the Plan may not be assigned, transferred, or pledged to a third party, for example, as security for a loan or other debt, except to repay bona fide debts to the Company.

No Guarantee of Employment

Your participation in, eligibility for, or your right to benefits under the Plan is no guarantee of continued employment with the Company. Nothing in this SPD or the Plan itself will restrict the Company's right to terminate your employment.

Plan Administration

Plan Name and Type

The name of the Severance Plan is the PanTeXas Deterrence, LLC Severance Plan for Non-Bargaining Unit Employees, a component plan under the PanTeXas Deterrence, LLC Group Welfare Benefit Plan. The Plan is considered a "Welfare Plan" under ERISA.

Name and Address of Plan Sponsor and Employer

The Plan is sponsored by:

PanTeXas Deterrence, LLC
P.O. Box 30020
Amarillo, TX 79120-0020
Telephone: 1-806-573-1100
Employer Identification Number: 92-3671850

Plan Number

The number assigned to the Plan is 501.

Plan Administration

The Benefits and Investment Committee is designated as the Plan Administrator and named Fiduciary for the Plan under ERISA and can be contacted at the address above. All communications to the Plan Administrator should be directed to the Director of Employee Benefits.

The Plan Administrator is responsible for the operation and administration of the Plan. The Plan Administrator has the absolute and exclusive discretionary authority to (i) construe and interpret the terms of the Plan, (ii) administer the Plan, and (iii) decide all questions of eligibility for benefits under the Plan and the amount of such benefits. Benefits under the Plan will be paid only if the Plan Administrator determines that the participant is entitled to the benefits. All decisions of the Plan Administrator are final, conclusive, and binding for all affected parties. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). The Plan Administrator is authorized to delegate some or all of its administrative responsibilities regarding the Plan to a committee or individual.

Plan Year

The Plan and its records are kept on a plan-year basis. The plan-year is the 12-month period beginning January 1 of each year and ending the following December 31.

Agent for Service of Legal Process

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

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

Legal process may also be served upon the Plan Administrator.

Plan Funding

The Company pays the entire cost of the Plan from its general assets pursuant to the terms of the Company's Contract with the NNSA.

Plan Amendment and Termination

The Company in its sole discretion reserves the right to amend or terminate the Plan at any time, without notice. Any amendment will not affect the Plan benefits of those who have already been approved for Plan benefits. Benefits for other employees, however, may be reduced, modified, or eliminated at any time. Prior practices by any employer, any entity related to the Company, or any predecessor contractor shall not diminish in any way the rights granted to the Company under this section.

Oral and other informal communications made by the Company or the Company's representatives shall not give rise to any rights or benefits other than those contained in the Plan as described herein, and no oral or other communication may diminish the Company's rights to amend or terminate the Plan in any manner.

This Plan rescinds and supersedes any and all prior non-bargaining unit Employee layoff allowance or severance plan, including any severance plan or policy adopted by any predecessor contractor. No person shall have any vested right to any benefit under the Plan. The severance pay provided in accordance with this Plan is not a vested benefit and may be modified or terminated at any time upon amendment by the Company.

Statement of ERISA Rights

The following statement is required by federal law and regulations.

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Services) 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report (if one is filed for the Plan). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a 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 $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, in no event will you be allowed to file suit in state or federal court until you have exhausted the administrative remedies available under the Plan, including following the Plan’s claims procedure described above.

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, 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, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Voluntary Plans

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Voluntary Plans

The Voluntary Plans provided by MetLife offer Group Supplemental Insurance coverage and other services at significant cost savings over individual insurance. Eligible employees can enroll in the Accident Insurance, Cancer Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, and/or Legal Plan during Open Enrollment by visiting www.mybenefits.metlife.com or by calling 1-800-438-6388.

Some other voluntary plans are closed to new participants (for example, other Group Voluntary Critical Illness Insurance and Cancer/Specified Disease Insurance offered by Allstate Workplace Division). Additional information about those closed plans is available directly from Allstate.

Accident Insurance

Accident Insurance pays a benefit for covered accidental injuries. This plan is offered by MetLife. You can use the payment for whatever you see fit, such as out-of-pocket expenses not covered by your health insurance (e.g., deductibles, copays). More than 150 covered conditions associated with an accident could trigger benefits, including various injuries, hospitalization, medical services, and treatments. Payments are made directly to you.

Critical Illness Insurance

Critical Illness Insurance provides you with a lump-sum payment that can be used to pay for everyday living expenses and out-of-pocket medical costs, like copays and deductibles, if a serious illness happens to you or a loved one. This insurance is offered by MetLife and covers conditions such as heart attack, cancer, or stroke. It also pays for an annual health screening benefit.

Cancer Insurance

Cancer Insurance pays a lump-sum benefit if you or a covered family member experience a covered cancer or a recurrence of cancer. This insurance is offered by MetLife and pays benefits for initial diagnosis and recurrence. Your premium is based on your age at the time your coverage becomes effective, and your rates will not increase due to age. Your coverage also pays for an annual health screening benefit.

Hospital Indemnity Insurance

Hospital Indemnity Insurance pays a lump-sum benefit if you or a family member is admitted or confined to a hospital due to an accident or illness. This plan is offered by MetLife. This benefit can help pay for out-of-pocket costs, such as deductibles and copays—or for anything that you see fit. Payments are made directly to you, not your health care provider. Coverage is portable, meaning you can take it with you if your employment status changes.

MetLaw Legal Services

The MetLaw Legal Services plan provides affordable assistance for a wide range of legal needs, including wills and other estate planning documents, real estate matters, traffic offenses, adoptions, debt collection defense, and much more. You receive unlimited use of plan services and access to more than 14,000 professionally selected network attorneys. No copay is accessed when using a Network Attorney.

ID Theft Protection

ID Theft Protection helps overcome the growing problem of identity theft. This plan provided by Allstate offers the services of licensed investigators—professionals specially trained to recognize the intricacies of identity theft and resolve the problem. You can enroll by visiting www.MyAIP.com/Pantex. Enrollment can occur upon initial employment or during Open Enrollment.

Long Term Care (Closed to New Participants)

Pantex Employees participating in the Long-Term Care plan may contact the Long-Term Care vendor, Prudential at 1-800-732-0416.

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The Glossary

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Glossary

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

Acts of Terrorism (Terrorism)
For Business Travel Accident Coverage

- Premeditated, politically motivated violence perpetrated against a non-combatant by:
  - Persons not acting on behalf of a sovereign state, or
  - Clandestine state agents.

Ad Hoc Employee
A non-exempt employee who works on an on-call, as-needed basis and is not eligible for Company benefits as an active employee.

After-Tax Contributions
Your after-tax contributions are deducted from your eligible earnings after income taxes are withheld and do not provide the advantages of deferring your taxes that are available through before-tax contributions.

Appropriate Care and Treatment
During disability, medical care and treatment that is:

- Received from a licensed physician whose medical training and clinical experience are suitable for treating your disability
- Necessary to meet your basic health need and is of demonstrable medical value
- Consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research and health care coverage organizations and government agencies
- Consistent with the diagnosis of your condition
- Maximizing your medical improvement

Approved Rehabilitative Employment Program
During disability, a program of physical, mental, or vocational rehabilitation which:

- Is expected to result in your return to your own occupation or to a reasonable occupation on a full-time basis
- Is approved, in writing, by the Company and the Claims Administrator

A rehabilitative employment program will no longer be considered approved on the earliest of these dates:

- The date you are able to perform the material duties of your own occupation
- The date you return to work for the Company on a reduced-hour basis
- The date the Claims Administrator or the Company withdraws, in writing, its approval of the program

Before or Pre-Tax Contributions
Your before-tax contributions are deducted from your eligible earnings before federal and, in most cases, state and local taxes are determined. (Social Security taxes are not affected.) By electing before-tax contributions, you reduce your current taxable income and, therefore, your current annual tax liability.

Beneficiary

The person, organization, or trust that you name to receive any Life, Accident, Pension Plan, or 401(k) Savings Plan benefits if you die.

Benefits and Investment Committee (BIC)
Appointed by the Company's board of managers to serve as the Plan Administrator for Company benefit plans.

Benefits Appeals Committee (BAC)
Considers escalated participant appeals related to eligibility, benefit determination, or denials not delegated to other Third-Party Administrators.

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

- Have available at all times, under an established agreement, the services of a licensed physician;
- Maintain daily medical records on all patients; and
- Have agreements with hospitals that will accept patients requiring immediate inpatient hospital care.

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

Bomb Scare/Search/Explosion/Felonious Assault Accident
For Business Travel Accident Coverage
"Bomb" means any real or dummy explosive device placed with intent to damage, scare, or cause injury. "Scare" means any real or false report of the presence of a bomb on the premises of the Company. "Search" means any organized search of a reported bomb. "Explosion" means any artificially induced explosion of a bomb on the Company's premises where it appears that the explosion was intended to cause injury or unlawful property damage, whether or not the presence of the bomb was reported before the explosion occurs. "Felonious Assault" means only those covered losses caused by other than a fellow employee or family member as a result of a Felonious Assault upon the insured person while on the premises of the Policyholder to which the insured person is permanently assigned.

Business Trip
For Business Travel Accident Coverage
Travel authorized by the Company (including trips outside the United States), including relocation trips, home leaves, and rest and relaxation leaves, as well as any side trips or vacations taken in conjunction with a business trip.

Calendar Year Annual Deductible
Individual Deductible (All Medical Plans)
The amount you pay on an individual plan before eligible claims are paid under the Plan's Coinsurance arrangement.

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

All Other Medical Plans
After an eligible family member meets his or her individual Deductible, Covered Expenses for that family member will be paid based on the Coinsurance level specified by the Plan. The other eligible family members continue to contribute toward the remaining portion of the family Deductible. After the family Deductible has been met, Covered Expenses for each eligible family member will be paid based on the Coinsurance level specified by the Plan.

Cause
When used in the context of a termination from employment, cause means a termination of employment due to poor performance, misconduct, or a willful violation of the Company's rules or policies.

Child
For Medical, Prescription Drugs, Dental, Vision, Health Care Spending Account and Employee Assistance Program, a Child is defined as:

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

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

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

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

A Child who is permanently and totally disabled and incapable of self-support (as determined by the Plan Administrator) before reaching the maximum coverage age above may continue to be covered regardless of age provided that he or she remains permanently and totally disabled and is primarily dependent on you for support.

For Business Travel and Special Accident Insurance Coverage
Your biological Child, stepchild, foster Child, legally adopted Child, or Child of adopting parents, pending adoption, who relies chiefly on you for support and maintenance.

Child Care Center

For Life Insurance
A facility which is run according to law, including laws and regulations applicable to child care facilities and provides for care and supervision of children in a group setting on a regular daily basis. A child care center does not include a hospital, a Child's home, or care provided during normal school hours.

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows you and your Eligible Dependents to continue health care coverages under certain circumstances when coverage would otherwise end.

Code
The Internal Revenue Code of 1986, as amended.

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

Company or Employer
Management and Operating contractor for the Department of Energy at the Pantex Plant in Amarillo, Texas. The current Management and Operating contractor is PanTeXas Deterrence, LLC.

Company Service
Company Service is service that is used to determine your eligibility for a benefit in a Pension Plan. It includes the total elapsed time between the first day you became an Employee with the Company (and prior Pantex Management and Operating contractors) and your last day at work as a Company Employee. Company Service does not include time spent as a former leased employee, as an independent contractor, or as an employee of a parent company, or of a different corporate entity in which the parent company has an ownership interest.

Company Service is also used to determine eligibility for Company service awards and paid time off accrual.

Conversion Privilege
Your right to convert a group Medical, Life Insurance, or Special Accident Insurance Policy to an individual policy.

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

Credited Service
Credited Service is service that is used to determine your eligibility for Plan participation and your vested interest in the Plan. It includes all the time you work for the Company (and prior Management and Operating contractors that maintained the Plan), from your first hour of service until you sever from service.

Recognition of Credited Service may be granted for service with a parent organization, as that term is defined by and as provided for in NNSA Supplemental Directive 350.1, *Management and Operating Contractor Service Credit Recognition* (approved Feb. 5, 2009), and as provided in the Plan. In addition, recognition may be granted for former leased employees who become Employees of the Company.

Credited Service will be used for Pension Plan and 401(k) Savings Plan participation, vesting, and Short-Term Disability accrual.

For parent company employees only, Credited Service will also be used to determine eligibility for early retirement.

Crown

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

Deductible
The Deductible is the amount you and your Eligible Dependents are required to pay each year for Covered Expenses before the Plan pays, and is in addition to any Coinsurance or Copayments. The Deductible amount does not apply to In-Network preventive care and immunizations.

Dependent Parent
For Dependent Care Flexible Spending Account
Your natural parent or stepparent who qualifies as your dependent for federal income tax purposes.

Disability
You are determined to have a Disability if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the Appropriate Care and Treatment of a Licensed Practicing Physician. The Company's Claims Administrator makes that determination.

Durable Medical Equipment
Any equipment which can withstand repeated use and is medically essential to treat an injury or sickness.

Early Retirement
Retirement prior to reaching age 65.

Elective Surgery
A surgical procedure which is not considered emergency in nature and which may be avoided without undue risk to the patient.

Eligible Dependents
For Medical, Dental, Vision, Health Care Spending Account, and Employee Assistance Program coverage
Your Eligible Dependents are:

- The person who is recognized under applicable law as your Spouse
- A Child described above in this Glossary

For Business Travel Accident Insurance and Special Accident Insurance coverage
Your Eligible Dependents are your Spouse under age 70 and your unmarried Child(ren) from birth through 18 years of age. An unmarried Child under age 28 is also considered your Eligible Dependent if he or she is enrolled as a Full-Time Student.

For Spouse and Dependent Life Insurance
Your Eligible Dependents are your Spouse under age 70 and your unmarried Child(ren) from age 6 months to 19 years (up to age 24, if a Full-Time Student).

Eligible Earnings

For the 401(k) Savings Plan at Pantex

All compensation that runs through payroll except for: expense reimbursements, moving expenses, clothing allowances, collective bargaining agreement ratification bonuses.

For the Pension Plan(s) at Pantex Non-Bargaining

Your base salary for straight time hours worked, not to exceed straight time hours included in your normal shift, plus vacation and sick leave buy-outs.

For the Pension Plan(s) at Pantex MTC and PGU

Your base rate in contract for straight time hours worked, not to exceed straight time hours included in your normal shift.

Eligible Employee

With respect to a benefit plan, an employee who has satisfied the eligibility and waiting period requirements, if any, for such benefit plan.

Eligible Retirement Plan(s)

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

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

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

- Excess plans,
- Top Hat plans, and
- Stock Option plans.

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

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

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

Employee(s)
Any person who is employed by the Company, is shown as a Company Employee in Company's personnel records and on the Company payroll, and who is receiving compensation from the Company from which the Company is withholding income tax. "Employee" **does not** include any person who the Company classifies as an independent contractor or who otherwise provides services to the Company if that person does not meet each of the criteria stated herein.

For purposes of these benefit plans, Employee does not include any bargaining unit construction personnel who are referred to work at Pantex pursuant to the West Texas Building and Construction Trades Council Agreement.

ERISA
The Employee Retirement Income Security Act of 1974, as now in effect and hereafter amended, and any regulations issued under ERISA.

Final Average Earnings for the Pantex Pension Plans
The average earnings during the five consecutive calendar years which provides the highest average out of the last 10 calendar year period which precedes the calendar year during which the participant's retirement date, date of termination, or date of death occurs, whichever is earlier. In the event that a participant does not receive earnings for at least five consecutive calendar years, Final Average Earnings will be determined from the average annual earnings during the total consecutive calendar years.

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

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

Full-Time Employee
A non-exempt employee who is scheduled to work at least 40 hours per week on a regular basis or an exempt employee who is scheduled to work at least 80 hours bi-weekly on a regular basis.

Full-Time Student
For Flexible Spending Accounts, and Life Insurance plans
A person who is enrolled full-time in any accredited school, including a trade or vocational training program.

Full-Time Temporary Employee
A non-exempt employee who is scheduled to work at least 40 hours per week on a temporary basis or an exempt employee who is scheduled to work at least 80 hours bi-weekly on a temporary basis.

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

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

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

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

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

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

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

Hour of Service
Generally, each hour for which you are paid or entitled to payment for the performance of duties for the Company.

Hour of Work
Each hour of work for the Company for which you are paid, including straight-time, overtime, holidays, and jury duty.

Imputed Income
The IRS requires you to be taxed on the value of employer-provided Group Life Insurance over $50,000. The taxable value of this Life Insurance is called “Imputed Income.” Even though you do not receive cash, you are taxed as if you received cash in an amount equal to the value of this coverage. IRS issues rate tables for purposes of imputing income under Group Term Life Insurance.

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

In-Network Benefits
Health care services or items provided by your primary care physician, or authorized services or items provided by another Participating Provider contracted with your insurance provider.

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

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

Leased Employee
Leased Employee is defined by the Code at section 414(n)(2).

Light Duty Assignments
Temporary modified duties assigned as the result of temporary physical limitations due to injury, illness, or pregnancy that prevent an employee from performing the full scope of duties of his or her regular assigned job.

Limb
An arm or a leg.

Long-Term Disability
Benefits for which you may become eligible after you have been totally disabled for six months.

Loss
For purposes of Life Insurance plans, loss of hand or foot means complete severance through or above the wrist or ankle joint. Loss of eyesight means the complete or irrecoverable loss of entire sight of either eye. Loss of speech means complete inability to communicate audibly in any degree. Loss of hearing means irrecoverable loss of hearing which cannot be corrected by any hearing aid or device. Loss of thumb and index finger means actual severance through or above the joint closest to the wrist. A loss must result directly from bodily injuries caused by an accident.

Maximum Reimbursable Charge
For the Medical Plan
A rate that the Claims Administrator determines is the normal charge made by providers in your geographic area for a similar service or supply. The nature and severity of the injury or sickness will be considered. If the Claims Administrator considers your medical expenses more than reasonable and customary, you will be responsible for paying the additional amount. Charges in excess of the Maximum Reimbursable Charge do not count toward your Deductible or Out-of-Pocket Maximum.

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

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

For Dental Coverage
A rate for dental services that is determined by the Claims Administrator by taking into account:

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

If the Claims Administrator considers your dental expenses more than reasonable and customary, you will be responsible for paying the additional amount. These charges do not count toward your Deductible.

Member Services / Customer Services / Participant Services
The customer service unit of the Plan's third-party vendor or Claims Administrator with responsibility for administering or insuring the Plan of benefits.

Mental Health Provider
The Company responsible for authorizing mental health and alcohol/drug abuse treatment for Medical Plan participants.

Minimum Essential Coverage, Minimum Value, and Affordability
Any insurance plan that meets the Affordable Care Act requirement for having health coverage.

Myofunctional Therapy
Correcting and/or retraining of the muscles in order to correct an orthodontia disorder.

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

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

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

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

Normal Retirement
Retirement at age 65.

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

One-Year Break in Service
A period of 12 consecutive months following your severance date during which you do not perform an hour of service.

Orthodontia Treatment
Treatment of the movement of teeth in the correction of malocclusion.

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

Out-of-Network Benefits
Care that is provided by a physician, facility, or other service provider not contracted with the Third-Party Administrator that does not qualify as In-Network.

Out-of-Pocket Maximum

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

Paralysis
The loss of all practical use of a limb as it relates to the ability to perform the normal functions and activities of everyday life without the use of a prosthesis or any other mechanical device(s).

Partial Denture
An appliance supporting artificial teeth less than the full number of teeth in one jaw.

Part-Time Employee
An employee who is scheduled to work 20 to 39 hours during a work week.

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

Pay
All of your total pay from the Company under Code Section 3401(a) during each calendar year ("Plan Year"), computed as of the date you became eligible to participate in a Plan.

Pay *includes*:

- Any amounts contributed by the Company to a Plan pursuant to a salary reduction agreement;
- Regular pay after severance of employment paid by the later of two-and-a-half months after severance of employment if the payment:
  - Is regular compensation for services you provided during your regular working hours or compensation for services outside of your regular working hours (for example, shift differential), commissions, bonuses, or similar payments; and
  - Would have been paid to you before a severance from employment if you had continued working for the Company. Any other payment paid after severance of employment is not considered to be compensation under the Plan even if payment is made within the two-and-a-half-month period.

For Short-Term Disability and Long-Term Disability

- Your basic rate of pay in effect just before your total disability begins and before any before-tax salary reductions. Pay does not include overtime, bonuses, or any other form of extra compensation.

For Life and Accident Insurance Benefits

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

For Retirees

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

Pay does not include:

- Reimbursements or other expense allowances, fringe benefits (cash or non-cash), moving expenses, deferred compensation, and welfare benefits (even if includible in gross income);
- The taxable value of stock options during the calendar year in which the option is exercised;
- Any form of compensation which, in accordance with applicable regulations of the United States Department of Energy, may not be reimbursed to the Company as an "allowable cost;" and
- Any form of compensation not paid from the Company's payroll.

Pension Service Credit

Pension Service Credit is the service used in the pension formula to determine the amount of your pension benefits. It is equal to your Company Service while participating in the Plan, excluding certain breaks during which you are not working for the Company, or for which you did not make a contribution to the Pension Plan, if the Plan requires a contribution. The same service will not be counted in the pension formula if you are owed benefits under more than one Pension Plan.

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

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

Personal Identification Number (PIN)
The number that allows you to access your 401(k) Savings Plan account information through the information line.

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

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

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

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

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

Qualifying Life Event
An event described in the "About Your Benefits" section which permits a change in coverage or election on a pre-tax basis.

Rollover Contributions
Distributions from another employer's qualified plan that you deposit into your 401(k) Savings Plan account.

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

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

Short-Term Disability
The Short-Term Disability plan is designed to protect your income if you are unable to work due to illness, injury, or pregnancy not to exceed six months.

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

Space Maintainers

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

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

Statement of Health
A licensed Physician's assessment of a person's health.

Total Disability or Totally Disabled
For Basic and Group Universal Life (GUL) Insurance
You are considered Totally Disabled if, because of an illness or injury:

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

For Long-Term Disability
During the first 24 months you are absent from work under the Long-Term Disability plan, you are considered Totally Disabled if you are unable to perform the duties of your regular job with the Company due to illness or injury and are under the regular care of a licensed Physician.

For 401(k) Savings Plan
For purposes of determining whether an exception to the 10% premature distribution penalty applies, disability means a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you unable to engage in any substantial gainful activity.

Totally and Permanently Disabled
For Business Travel Accident and Special Accident Insurance Coverage
You are considered totally and permanently disabled if, as the result of a qualifying accident, you cannot do any work for which you are or can become qualified by reason of your education, experience, or training, and you are not expected to be able to do so for the remainder of your life.

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

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

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

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

Year of Service
For the Pantex Pension Plans, a Year of Service means a 12-month Computation Period in which the employee completes 1,000 Hours of Service.

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Administrative Information

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Administrative Information

This section contains information on the administration and funding of all the plans described in this book, as well as your rights as a plan participant under the Employee Retirement Income Security Act of 1974 (ERISA). It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

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

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

Plan Sponsor

PanTeXas Deterrence, LLC is the sponsor of the employee benefit plans described in this book. You can reach the Plan Sponsor as follows:

PanTeXas Deterrence, LLC
P.O. Box 30020
Amarillo, TX 79120-0020
1-806-573-1100

Plan Administrator / Claims Administrator

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

Benefits and Investment Committee
PanTeXas Deterrence, LLC
P.O. Box 30020
Amarillo, TX 79120-0020
1-806-573-1100

In carrying out its responsibilities under the plans, the Benefits and Investment Committee, as the Plan Administrator, has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the Plan Administrator are final, conclusive, and binding on all persons.

The Plan Administrator may delegate some or all of these duties to other persons or entities. For example, the Plan Administrator has retained one or more Third-Party Administrators to provide certain administrative services with respect to one or more of the welfare plans, including making determinations as the "Claims Administrator" regarding participant claims for benefits. The contact information for the Claims Administrators is located later in this section of this book. In addition, with respect to the retirement plans, the authority to make initial claims determinations has been delegated to an employee of the Company. The appeals of such determinations are decided by the Benefits Appeals Committee. The Benefit Appeals Committee may be contacted as follows:

Benefit Appeals Committee
PanTeXas Deterrence, LLC
P.O. Box 30020
Amarillo, TX 79120-0020
1-806-573-1100

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

The term “Company” means PanTeXas Deterrence, LLC.

The term “Pantex Benefits Office” refers to the Company’s benefits department located in Amarillo, Texas.

Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to the Company is 92-3671850.

Plan Documents

This book summarizes the key features of each of the employee benefit plans sponsored by the Company and serves as the summary plan description for each of the plans for purposes of ERISA. It applies to eligible employees of the Company, including those represented by collective bargaining agreements to the extent that they have been negotiated and accepted by the duly certified representatives of participating units. Complete details of each of the plans can be found in the official plan documents, insurance contracts, and trust agreements (as applicable) that legally govern the operation of the plans. Summaries of the plans are included in the tabs of this book. **All statements made in this book are subject to the provisions and terms of the Plan Documents.**

Copies of those documents, as well as the latest annual reports of plan operations and plan descriptions as filed with the Internal Revenue Service or Department of Labor are available for your review any time during normal working hours in the office of the Plan Administrator. Upon written request to the Plan Administrator, at the address previously mentioned, copies of any of these documents will be furnished to a plan participant or beneficiary at a nominal charge. In addition, once each year you will receive a copy of the summary annual reports of the Plans’ financial activities (if applicable), which will be made available to you at no charge. In the event of a conflict between the official plan documents and the summaries in this book, the Plan Documents are controlling.

Depending on where you live, there may be state law requirements or mandated coverages for health and welfare plans. If the Company-sponsored plans have to comply with those requirements or mandated coverages, your benefits may vary from the benefits described in this book. Requirements under the law and the terms of benefits are set forth in the insurance company’s certificate of coverage for the insured coverage. In the event of any conflict between the summaries in this book and such certificate of coverage the provisions of such certificate of coverage shall control. You may request a copy of such certificate of coverage by following the steps outlined in the “Administrative Information” section of this book.

Claiming Benefits

You or your Beneficiary must file the appropriate forms to receive any benefits, or to take any other action under any of the plans, as described throughout this book. The procedure for claiming benefits and appealing the denial may differ for different types of plans and different types of benefits under each plan. The following section describes claims and appeals procedures based on the type of claim and the type of plan. All forms required to take any action under the plans are available through the Pantex Benefits Office or, in some cases, the Claims Administrator. All completed forms must be submitted to the appropriate office, as described throughout this book, within any time period required by the administrator.

You have the right to file a formal claim for benefits, ask whether you have a right to any benefits or appeal the denial of a claim for benefits under each of the plans. Your authorized representative may do this on your behalf. References to the term "you" in this section, include the participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person.

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

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

To make a formal claim for benefits, you must file a written claim with the Plan Administrator or, where applicable, the Claims Administrator. The way in which you file a claim for benefits and appeal any claim that is denied (or any other adverse benefit determination) will differ depending on the type of benefit that is offered under the Plan. An adverse benefit determination includes any denial, reduction or termination of a benefit, a failure to make a payment, or, in the case of the Company's medical plans and effective April 2, 2018, disability plans, a rescission of coverage. There are three types of claims procedures contained herein:

- The Health Claims Procedures, which are special procedures that apply to claims related to the Company's health plans.
- The Disability Claims Procedures, which are special procedures that apply to claims related to the Company's disability plans or any other benefit based on the Claims Administrator's determination of disability.
- The General Claim Procedures, which apply to claims related to all of the Company's other ERISA-covered plans.

Exhaustion of Administrative Remedies and Limitations on Actions

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

Failure to follow the administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination or any other matter covered by this provision.

Discretionary Authority

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

Health Claims Procedures

You may file claims for health plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs covered by the Health Claims Procedures include the medical plan, dental plan, vision plan, employee assistance program, and Health Care Flexible Spending Account.

Initial Health Claims

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

Urgent Health Care Claims

If you file an Urgent Care Claim, you will receive notice of the benefit determination as soon as possible, but not later than 72 hours after the claim is received unless you fail to provide sufficient information for the Plan to make a decision. Notice of the benefit determination may be oral, with a written or electronic confirmation to follow within 3 days.

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

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

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

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim (provided it is not an Urgent Care Claim). You will be notified of the decision as soon as possible, but not later than 15 days after receipt of the pre-service claim.

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

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

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

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

Ongoing Course of Health Treatment

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

Notification of Initial Health Claim Decision

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

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings)
- The specific reasons for the adverse benefit determination, including the denial code (and its meaning), and a description of any standard that was used in denying the claim
- References to the specific plan provisions on which the benefit determination is based, including plan limitations or exclusions
- A description of any additional information needed to complete the claim and an explanation of why such information is necessary
- A description of the Plan's internal claim review procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
- A description of available external review processes, including information regarding how to initiate any appeal

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

For all other claims and adverse benefit determinations relating to any other health plan, including the dental plan, vision plan, employee assistance program and Health Care Flexible Spending Account, the Claims Administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

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

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

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

Appeal of a Health Claim

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial determination will be final.

To file an appeal, you must submit it in writing to the Claims Administrator, except for Urgent Care Claims. If you appeal, you will be notified of the decision not later than 72 hours (Urgent Care Claim), 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information "relevant" to the claim (as that term is defined in ERISA).

The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision regarding the claim and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

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

In reconsidering any denial that is based in whole or in part on a medical judgment, (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate) the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in

the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the Plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the Plan relies on their advice in making any benefit determinations.

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

Notification of Health Claim Appeal

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

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

For appeals that relate to any other health plan, including the dental plan, vision plan, employee assistance program, and Health Care Flexible Spending Account, if your appeal is denied in whole or in part, the Claims Administrator will provide you with a written or electronic notification that will include:

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

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

circumstances, or a statement that such an explanation is available will be provided to you free of charge upon request.

The Plan's claims review procedures do not generally include any voluntary levels of appeal (such as voluntary arbitration). Although, you may request an external review of certain types of medical plan claims. This external review process is completely voluntary.

Your Right to an External Review

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

Types of Eligible Determinations

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

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

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

External Review Request

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

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

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

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

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

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

Procedures After your External Review Request is Approved

If your external review request is eligible, the Claims Administrator will assign it to an Independent Review Organization (IRO) as required under federal law to conduct the external review. The assigned IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the assigned IRO within 10 business days following the date the notice is received additional information that the IRO must consider when conducting the external review. Any additional information received by the IRO from you will be shared with the Claims Administrator and the Plan. Upon receipt of this information by the Claims Administrator and the Plan, the Claims Administrator may reconsider its prior appeal decision and may reverse the prior denial of the internal appeal. If the Claims Administrator reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly and the external review will be terminated.

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

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

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

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An

IRO must make such records available for examination by the claimant, plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

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

Expedited External Review Requests

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

- The Claims Administrator must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- Upon a determination that a request is eligible for external review following preliminary review, the Claims Administrator will assign an IRO. The IRO will provide notice of the external review decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, the Claims Administrator and the Plan.

Foreign Language Assistance (Medical Plan only)

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

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

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the Claims Administrator or the Pantex Benefits Office.

Disability Claims Procedures

You may file claims for disability plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative you or a court appoints. Benefit programs covered by the disability claim procedures include the Long-Term Disability plan. These procedures may apply to other Benefit Programs if the Claims Administrator of that program must determine that you (or your dependent) are disabled in order to receive a benefit under that program.

Initial Disability Claims

If you file a claim for disability benefits, you will receive a notice from the Claims Administrator regarding the claim according to the procedures described below.

If you file a claim for disability benefits, you will be notified of the Plan's benefit determination not later than 45 days after the Plan's receipt of the claim. The time period may be extended up to an additional 30 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 45-day period. If a decision cannot be made within this 30-day extension period due to circumstances outside the Plan's control, the time period may be extended up to an additional 30-day extension period, in which case you will be notified of the additional extension before the end of the initial 30-day extension. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

Notification of Initial Disability Claim Decision

The Claims Administrator will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

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

In all cases, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request, or for claims filed after April 1, 2018, a statement that such rule, guideline, protocol or other similar criteria does not exist.

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

For claims filed after April 1, 2018, the notice will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) (1) the views that you present of the health care professionals treating you and of the vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and/or (3) a determination made by the Social Security Administration that you are disabled.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits.

Appeal of a Disability Claim

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not later seek a reconsideration of your claim, and the initial claim determination or other adverse benefit determination will be final.

To file an appeal, you must submit it in writing to the Claims Administrator. The contact information for the Claims Administrator is located at the end of this Administrative Information section.

You will be notified of the decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information "relevant" to the claim (as that term is defined in ERISA). The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

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

For claims filed after April 1, 2018, before your appeal is decided, you will be given, free of charge, any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with your claim. This evidence will be given as soon as possible and sufficiently in advance of the date on which the appeal decision is required to be provided to give you a reasonable opportunity to respond before that date.

Notification of Disability Claim Appeal

If your appeal is denied in whole or in part, the Claims Administrator will provide you with a written or electronic notification that will include:

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

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

For claims filed after April 1, 2018, the notice will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (as applicable) (1) the views that you present of the health care professionals treating you and of the vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to

whether the advice was relied upon in making the benefit determination; and/or (3) a determination made by the Social Security Administration that you are disabled.

- A description of the Plan's limitation period (including the calendar date) for bringing a legal action following a decision on appeal.

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

Foreign Language Assistance

For claims filed after April 1, 2018, if you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with government data), you will be entitled to receive foreign language assistance services with respect to your claim or appeal. The services that you are entitled to receive are described in the health plan claims section.

General Claims Procedures (Non-Health and Non-Disability)

You may file claims for plan benefits, either yourself or via an authorized representative appointed by you or the court. Either you or your authorized representative may appeal an adverse claim decision. Benefit programs that are covered by the General Claim Procedures include the Pension Plan, the 401(k) Savings Plan, the Life and Accident Coverage Plan and the Long-Term Care Plan. In addition, even though the Dependent Care Flexible Spending Account plan is not subject to ERISA, claims related to that program are also handled under these General Claims Procedures.

Initial General Claims (Non-Health and Non-Disability Claims)

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

If you file a claim for non-health or non-disability benefits, you will be notified of the Plan's benefit determination not later than 90 days after the Plan's receipt of the claim. The time period may be extended up to an additional 90 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 90-day period.

Notification of Initial Claim Decision

The Plan Administrator (or Claims Administrator for non-retirement benefits) will provide you with a written or electronic notification of any adverse benefit determination, including any claim for plan benefits which is denied in whole or in part, that will include:

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

Appeal of a General Claim (Non-Health and Non-Disability Claim)

If your claim is denied or you receive some other type of adverse benefit determination, you may request that it be reviewed. You will have 60 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not seek a reconsideration of your claim later, and the initial claim determination or other adverse benefit determination will be final.

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

You will be notified of the decision no later than 60 days after the appeal is received. If special circumstances require an extension of time of up to an additional 60 days, you will be notified of such extension during the 60 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information "relevant" to the claim (as that term is defined in ERISA). The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination.

Notification of General Claim Decision on Appeal

If your appeal is denied in whole or in part, the Benefits Appeals Committee, Plan Administrator, or Claims Administrator will provide you with a written or electronic notification that will include:

- The reasons for the decision, again with reference to the specific plan provisions on which that decision is based
- Your right to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits,
- Your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and within any applicable time limit to file the action. In the case of the pension and 401(k) Savings Plans, the lawsuit must be filed within one year of the date of the final decision on appeal.

Legal Process

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

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

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

Plan Termination and Amendment

The Company expects and intends to continue the plans in your benefits program, but reserves its right to amend and/or terminate each of the plans, in whole or in part, without notice. The Company may also increase or decrease its contributions or the participants' contributions to the plans.

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

If the Pension Plan or 401(k) Savings Plan is terminated while you are an employee of the Company, you will become immediately vested in your accrued retirement benefit under the Pension Plan or the entire value of your 401(k) Savings Plan account, as applicable.

If a welfare plan is terminated, you will not have any further rights, other than the payment of benefits for covered losses or expenses incurred before the Plan was terminated. The amount and form of any final benefit you or your beneficiary receives will depend on any insurance contract provisions affecting the Plan and the Company's decisions.

Special Pension and 401(k) Savings Provisions

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

Maximum Benefits

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

Top-Heavy Provisions

Under current tax law, the Pension Plan and 401(k) Savings Plan are required to contain provisions that apply in the event that a significant portion of the Plan's benefits are payable to highly compensated employees. These provisions – called "top-heavy" rules – provide for accelerated vesting of plan benefits and certain minimum benefit accruals in the event the plans become top-heavy. The plans are not top-heavy now. The top-heavy rules are not likely to affect your benefits under the Plans.

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

Assets Upon Termination

If the 401(k) Savings Plan terminates, participants' accounts will be distributed after plan expenses are paid. The trustee will make account distributions as instructed by the Plan Administrator.

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

Pension Benefit Guaranty Corporation

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits, within limits applicable at that time.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits payable by the Pension Plan if you become disabled before the Plan terminates
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates
- Some or all of benefit increases and new benefits-based plan provisions that have been in place for fewer than five years at the time the Plan terminates
- Benefits that are not vested because you have not worked long enough for the Company
- Benefits for which you have not met all of the requirements at the time the Plan terminates
- Certain Early Retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an Early Retirement monthly benefit greater than your monthly benefit at the Plan's Normal Retirement age

- Non-pension benefits such as health insurance, Life Insurance, certain death benefits, vacation pay, and severance pay.

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

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC's Technical Assistance Division.

Assignment or Alienation of Benefits

Except as required by applicable law (such as a qualified domestic relations order), benefits provided under the Pension Plan and 401(k) Savings Plan are not subject to assignment, alienation, attachment, lien, garnishment, levy, pledge, bankruptcy, execution, or any other form of transfer.

Qualified Domestic Relations Order

A qualified domestic relations order (QDRO) is a legal judgment, decree, or order that recognizes the rights of another individual under the 401(k) Savings Plan or Pension Plan with respect to child or other dependent support, alimony or marital property rights.

In the event of a QDRO, benefits under the Pension Plan and 401(k) Savings Plan may be payable to someone other than your designated Beneficiary to satisfy a legal obligation you may have to a Spouse, former Spouse, Child or other dependent. Your Pension Plan or 401(k) Savings Plan benefits will be reduced by the benefits payable under the QDRO to someone else.

There are specific requirements which a domestic relations order must meet to be recognized by the Plan Administrator as a QDRO, and specific procedures regarding the amount and timing of payments. If you are affected by such an order, you will be notified by the Pantex Benefits Office. Participants and Beneficiary(ies) may obtain, without charge, a copy of the Plan's procedures governing QDROs from the Plan Administrator.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a legal order requiring a parent to provide medical support to a Child (for example, in cases of legal separation or divorce). In order to qualify as a QMCSO, the Medical Support Order must be a judgment, decree or order that is issued by an appropriate court or administrative agency and contains certain information. A QMCSO must be provided to the Plan Administrator. A QMCSO must be specific as to the plan, the participant whose Child(ren) is (are) to be covered, the type of coverage, the Child(ren) to be covered and the length of coverage. The QMCSO may not require the plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan.

Health Insurance Portability and Accountability Act (HIPAA)

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

Newborns' and Mothers' Health Protection Act of 1996

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

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

Coverage for Reconstructive Surgery Following Mastectomy

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

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

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

ⓘ Genetic Non-Discrimination Act (GINA)

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

Compliance with the Affordable Care Act

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

Other Administrative Facts

Specific Plan Information

Plan name	Plan number	Plan type	Plan year
Retirement Plan for Bargaining Unit Employees of the Metal Trades Council of PanTeXas Deterrence, LLC	002	Defined Benefit	Calendar
PanTeXas Deterrence, LLC Retirement Plan for Bargaining Unit Members of the Pantex Guards Union	008	Defined Benefit	Calendar
PanTeXas Deterrence Retirement Plan for Non-Bargaining Pantex Location Employees	010	Defined Benefit	Calendar
PanTeXas Deterrence 401(k) Plan for Bargaining Pantex Location Employees	012	Defined Contribution and 401(k) Plan	Calendar
PanTeXas Deterrence 401(k) Plan for Non-Bargaining Pantex Location Employees	013	Defined Contribution and 401(k) Plan	Calendar
The PanTeXas Deterrence, LLC Group Welfare Benefit Plan provides for the following benefits:			
Group Life Insurance	501	Welfare	Calendar
Business Travel Accident	501	Welfare	Calendar
Special Accident Insurance	501	Welfare	Calendar
Health Benefits (Medical, Dental, Vision, Prescriptions)	501	Welfare	Calendar
Long-Term Disability	501	Welfare	Calendar
Health Care Spending Account (under the Cafeteria Plan)	501	Welfare	Calendar
Employee Assistance Program	501	Welfare	Calendar
Severance Plan for Salaried Employees	501	Welfare	Calendar
Accidental Death & Dismemberment Insurance	501	Welfare	Calendar
Group Voluntary Insurance Benefits (Cancer/Specified Disease, Critical Illness and Legal Services)	501	Welfare	Calendar
On-Site Medical Clinic	501	Welfare	Calendar
Long-Term Care Insurance	501	Welfare	Calendar

Insurer, Claims Administrator, or Trustee	Source of contributions	Source of benefits
Northern Trust Company serves as Trustee The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Employee and Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
Voya Financial P.O. Box 55772 Boston, MA 02205-5772	Employee and Company	Benefits are funded by employee contributions, which can be Pre-tax or Roth basis
Group Life Insurance: Metropolitan Life Insurance Company	Employee/Retiree and Company	Benefits are paid from an insurance contract
BTA and Special Accident: Life Insurance Company of North America (New York Life)	Employee and Company	Benefits are paid from an insurance contract
Medical: Administered by Cigna Dental: Administered by MetLife Vision: Administered by Vision Service Plan (VSP) Prescription: Administered by Express Scripts	Employee/Retiree and Company	Benefits are paid through Claims Administrator and paid from employee contributions and general assets of the Company.
Long-Term Disability Plan: New York Life Disability (Fully insured) Company and an outside Claims Administrator (MetLife Disability)	Employee / Company Company	Benefits are paid from an insurance contract Company
Cafeteria Plan Dependent Care Flexible Spending Account Health Care Flexible Spending Account	Employee (Pre-tax contributions)	Benefits are paid (through a Claims Administrator) from employee contributions and general assets of the Company
Employee Assistance Program – Aetna	Company	Not applicable
Severance Plan for Salaried Employees	Company	Company
Accidental Death & Dismemberment Insurance – MetLife	Employee and Company	Benefits are paid from an insurance contract
Group Voluntary Insurance Benefits (Cancer, Critical Illness, Hospital Indemnity, Accident and Legal Services) – MetLife	Employee	Benefits are paid from an insurance contract
On-Site Medical Clinic	Company	Company
Long-Term Care Insurance – Prudential (closed plan)	Employee	Benefits are paid from an insurance contract

Your Rights Under COBRA

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

Certain aspects of COBRA continuation coverage are administered by Allegiance COBRA Services, Inc., which is referred to in this Section as the "COBRA Administrator." The contact information for the COBRA Administrator is www.askalliegance.com and 1-800-259-2738.

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

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

Eligibility and Coverage

You will become a Qualified Beneficiary if you lose your coverage under COBRA-Eligible Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- You die;
- Your hours of employment are reduced;

- Your employment ends for any reason other than your gross misconduct; or
- You and your Spouse divorce.

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

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You and your Spouse divorce; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

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

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

Special rules apply to the Health Care Flexible Spending Account. You and/or your Eligible Dependent(s) will be able to continue coverage under the Health Care Flexible Spending Account only if the maximum benefit available to you or your Eligible Dependent(s) for the remainder of the plan year is equal to or more than the maximum amount that you could be required to contribute to the Health Care Flexible Spending Account for the remainder of the plan year.

Required Notice of Qualifying Events

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

COBRA Election Period

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

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

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

Special COBRA rights may apply if you lose coverage because of termination of employment or a reduction in hours of employment and you qualify for a "Trade Readjustment Allowance" or "Alternative Trade Adjustment Assistance" under a federal law called the Trade Act of 2002. Generally, in this situation, you may be entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if you did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. In addition, eligible individuals can take a tax credit equal to 72.5% of the premiums paid for qualified health insurance, including COBRA coverage. Eligible individuals who elect to claim this tax credit will not be eligible for a premium subsidy through the Marketplace.

If you qualify or may qualify for assistance under the Trade Act, please contact the Benefits Plan Office for additional information. You must contact the Benefits Plan Office promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. More information can be found by visiting www.doleta.gov/tradeact or www.irs.gov/HCTC.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "Special Enrollment Period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov or by calling 1-800-318-2596.

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

Additional information is provided below.

Description and Maximum Length of COBRA Coverage

If you continue coverage, you will receive coverage identical to that provided under the COBRA-Eligible Plan for similarly situated employees or family members. If the Company changes the benefits provided under a COBRA-Eligible Plan during your COBRA continuation period, your COBRA continuation coverage will also be changed in the same manner.

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the Qualifying Life Event. If you or your Eligible Dependent(s) elect to continue coverage under the Health Care Flexible Spending Account, participation may continue only until the end of the year in which the Qualifying Life Event occurs. With respect to continuation coverage for all other COBRA-Eligible Plans, the time periods are described in general below.

- **36-Month Period.** When the Qualifying Life Event causing loss of coverage is your death, your divorce, or a Child losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. If the Qualifying Life Event is your death and your Eligible Dependent receives extended coverage under the medical plan (as described in the Medical Plans section), the maximum COBRA period will be reduced by the length of that extended coverage.
- **18-Month Period.** When the Qualifying Life Event causing loss of coverage is the end of your employment or reduction in your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA continuation coverage for other Qualified Beneficiary(ies) lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before your employment terminates, COBRA continuation coverage for your Spouse and Child(ren) can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Life Event (36 months minus 8 months).

If you become entitled to Medicare or first learn that you are entitled to Medicare after submitting your Election Form, you must notify the COBRA Administrator of the date of your Medicare entitlement at the address specified herein. The notice procedures are described below.

The maximum COBRA coverage period for your newborn or newly-adopted Child is measured from your original Qualifying Life Event. To be enrolled in a COBRA-Eligible Plan, the Child must satisfy the otherwise applicable plan eligibility requirements. A person who becomes the Spouse of a Qualified Beneficiary (including a new Spouse of an employee) or dependent Child of a Qualified Beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a Qualified Beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Described below are two ways in which the general 18-month period of COBRA continuation coverage can be extended.

- **Disability extension of 18-month period of continuation coverage:** If you or anyone in your family covered under the COBRA-Eligible Plan is determined by the Social Security Administration to be disabled and the COBRA Administrator is notified in a timely fashion, you and your family members who are receiving COBRA coverage may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Social Security Administration must determine that the disability started at some time before the 60th day of COBRA continuation coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In order to qualify for the extension, you or the disabled Qualified Beneficiary (or a representative) must notify the COBRA Administrator in writing of the Social Security Administration's

determination before the end of the 18-month period of COBRA continuation coverage and within 60 days after the later of (1) the date the Qualified Beneficiary is determined to be disabled by the Social Security Administration; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the Qualified Beneficiary would lose coverage under the Plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described below.

- **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another Qualifying Life Event while receiving 18 months (or 29 months in case of a disability extension) of COBRA continuation coverage, your Spouse and your Child(ren) in your family can get additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Life Event is properly given to the COBRA Administrator. This extension may be available to your Spouse and any Child(ren) receiving continuation coverage if you die or divorce, or if your Child stops being eligible as a dependent Child, but only if the event would have caused your Spouse or Child to lose such coverage under the Plan had the first Qualifying Life Event not occurred. In no event may a Qualifying Life Event give rise to a maximum coverage period that ends more than 36 months after the date of the first Qualifying Life Event. For cases of second Qualifying Life Events, the Qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the later of (1) the date of the second Qualifying Life Event; or (2) the date on which the Qualified Beneficiary would have lost coverage under the Plan due to the second Qualifying Life Event if it had occurred before the first Qualifying Life Event. The procedures for providing this notice are described below.

Failure to provide timely and properly provide notice of a disability determination or second Qualifying Life Event will eliminate the right to extend the period of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if any one of the following events occurs:

- The Qualified Beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA (provided the Plan does not have pre-existing condition exclusions affecting the covered individuals; if the other plan has such limitations, COBRA coverage will end when those limitations expire).
- The Qualified Beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the Social Security Administration makes a final determination that the Qualified Beneficiary is no longer disabled.
- The Company terminates its group health plans.

If, during the period of COBRA coverage, a Qualified Beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the Qualified Beneficiary (or a representative) must notify the COBRA Administrator in writing within 30 days of the later of:

- the date the other coverage becomes effective, or
- the exhaustion or satisfaction of any preexisting condition exclusions affecting the Qualified Beneficiary.

If, during the period of COBRA coverage, a Qualified Beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, you or the Qualified Beneficiary (or a representative of either) must notify the COBRA Administrator in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If the Social Security Administration determines that a Qualified Beneficiary is no longer disabled, COBRA coverage for all Qualified Beneficiary(ies) will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the determination. The Qualified Beneficiary must notify the COBRA Administrator in writing within 30 days after the Social Security Administration's determination that he or she is no longer disabled.

The procedures for providing this notice in both of these circumstances are described below.

If notice of these events is not timely and properly provided, the Qualified Beneficiary's COBRA coverage may be terminated retroactively and the Qualified Beneficiary may be required to repay a portion of the benefits received.

A Qualified Beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA coverage is provided subject to the Qualified Beneficiary's eligibility for coverage. The COBRA Administrator reserves the right to terminate a Qualified Beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible.

Premium Payments

A Qualified Beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

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

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

Notice Procedures

As a condition of receiving COBRA coverage, you or your Covered Dependent (or a representative) must notify the Plan Administrator or COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial Qualifying Life Events
- Second Qualifying Life Events
- A Qualified Beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Each of these events, including the time period for providing notice of the event, has been discussed previously. Unless directed otherwise in the COBRA election notice (if applicable):

- All other notices, including notice of a second Qualifying Life Event or a Qualified Beneficiary's determination or cessation of disability, must be provided to the COBRA Administrator. The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each Qualified Beneficiary experiencing the COBRA-related event, the name of the COBRA-Eligible Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled.

If mailed, the notice must be postmarked no later than the applicable deadline for giving the notice. If the notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all qualified Beneficiaries who are required to give the notice.

Additional documentation supporting the notice may be required. If such information is requested and it is not provided within 15 business days of the request, the notice will not be considered timely and continuation coverage may not be available.

Keep the Plan Informed

In order to protect your family's rights, you should keep the Company and the COBRA Administrator informed of any changes in the addresses of your family members. If you have changed your marital status, or you or your Eligible Dependents have changed addresses, it is your responsibility to notify the COBRA Administrator. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for Deductibles, Coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

There are time limits on enrolling in Marketplace coverage. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "Special Enrollment" event. After 60 days your Special Enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "Open Enrollment" period. The Open Enrollment period is the time during which anyone can purchase coverage through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next Open Enrollment period will be and what you need to know about qualifying events and Special Enrollment periods, visit www.HealthCare.gov.

If you enroll in COBRA Coverage, it may temporarily limit your Marketplace options. If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace Open Enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a Child through something called a "Special Enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next Open Enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a Special Enrollment period, even if you enroll outside of the Marketplace Open Enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Enrolling in another Group Health Plan

You may be eligible to enroll in coverage under another group health plan (like a Spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Factors to Consider when Choosing Coverage Options

When considering your options for health coverage, you may want to think about:

- Premiums: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance Payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. Keep in mind that when these payments stop, you will be required to pay the full COBRA premiums until you are allowed to enroll in the Marketplace which, in many cases, will not be until the next annual enrollment.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, Coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

Questions concerning your Medical Benefit Option or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

Your Rights under FMLA and USERRA

Leave Taken Under the FMLA

If you are covered under a group health plan (including the medical plan, dental plan, vision plan, employee assistance program, or Health Care Flexible Spending Account) and you take leave under the Family and Medical Leave Act of 1993, as amended (FMLA), you and your Eligible Dependents' coverage will continue under the plans to the extent required by the FMLA (that is, the Company will continue to pay its share of the contributions required and you must continue to make your contributions). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your contributions), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as required by the FMLA. Under special rules that apply if you do not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA continuation coverage even if they were not covered under one of the group health plans during the leave. Please contact the Plan Administrator for more information about these special rules.

Leave Taken Under the USERRA

If you are covered under a group health plan, including the medical plan, dental plan, vision plan, employee assistance program, or Health Care Flexible Spending Account, and are going into or returning from military service, you will have certain rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. As used herein, military service means service in the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

In particular, you have the right to continued coverage under the group health plans provided you give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Coverage may be continued until the earlier of (1) 24 months after your absence from work begins, or (2) the day after the date on which you fail to timely apply for or return to employment as required under USERRA. If you elect to continue coverage, you must timely notify the Plan Administrator of your election to continue coverage.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures which govern your right to COBRA continuation coverage also apply to your right to USERRA continuation coverage with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any Covered Dependents. Your Covered Dependents do not have an independent right to

make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your Covered Dependents, your Covered Dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If your military service is less than 31 days, you are required to pay only your normal share of the contribution for such coverage. If the length of your military service extends past 31 days, the Plan Administrator may require you to pay up to 102% of the contribution cost for coverage for similarly situated covered individuals who are not serving in a military service.

Plan exclusions may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

If you are called to active military duty, you and your Eligible Dependents may be eligible for coverage under Tricare, the military service's health plan. You and your Eligible Dependents may also elect to continue benefits under the Company's group health plan if you were covered by such plan at the time you were called to military duty.

If you choose not to continue coverage during your military service, you and your Eligible Dependents are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. As permitted by USERRA, your coverage will not include any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of military service. Any other such illness or injury will be covered, subject to all otherwise applicable conditions and limitations of the Plan.

As noted above, your USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins, but it could end earlier for any of the following reasons:

- You fail to pay the required premium on time
- You fail to return work within the time required under USERRA following the completion of your service
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

After your USERRA continuation coverage expires, you will not thereafter receive continuation of coverage under COBRA. However, if your USERRA coverage expires prior to the expiration of the continuation of coverage under COBRA (e.g., because you do not return to employment), you may be eligible for continuation of coverage under COBRA for the remainder of the original COBRA coverage period.

The above is only a summary of the FMLA and USERRA rights and limitations. If you wish to elect FMLA or USERRA coverage or obtain more detailed information, please contact the Plan Administrator.

Your Rights under ERISA

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all plan documents.
- Obtain, upon written request to the Plan Administrator, copies of all plan documents and other plan information. The Plan Administrator may charge a reasonable fee for copies.
- Receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition, you may request information concerning the total value of your 401(k) Savings Plan accounts by logging on to the Recordkeeper's website or calling the Recordkeeper. You may also receive a quarterly statement showing the value of your account, type of contributions and the amount that is vested.

Similarly, once each year, you may request information concerning your vested rights under the Pension Plan (or, if you are not vested, the earliest date on which you become vested), and what your benefit would be at Normal Retirement age if you stopped working under the Plan now. This information is free of charge, but you must address a written request for it to the Plan Administrator or, for 401(k) Savings Plan information, call the Information line.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Eligible Dependents if there is a loss of coverage under the plans as a result of a Qualifying Life Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

- If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, in no event

will you be allowed to file suit until you have exhausted the administrative remedies available under the plans, including following the appropriate claims procedure as described above.

- In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in federal court.
- If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Contact Information

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Contacts

The following chart provides contact information for questions you may have regarding benefits provided under the PXD Benefits Program:

For questions:	Contact:	At:
Enrollment and Benefits Information	Pantex Benefits Office	Phone: 1-806-573-1100 E-mail: benefitspantex@pantex.doe.gov
Medical	Cigna	Phone: 1-877-774-9913 www.myCigna.com
Prescription Drugs	Express Scripts	Phone: 1-877-765-6543 www.express-scripts.com
Dental	MetLife	Phone: 1-800-223-3104 www.metlife.com
Vision	Vision Service Plan (VSP)	Phone: 1-800-877-7195 www.vsp.com
Flexible Spending Accounts	Cigna	Phone: 1-877-774-9913 www.myCigna.com
401(k) Savings Plan	Voya Financial	Phone: 1-844-573-8692 https://pantex.voya.com
Employee Assistance Program	Aetna	Phone: 1-866-611-2826 www.resourcesforliving.com
Short-Term Disability (STD)	Pantex Absence Management	Phone: 1-806-573-1100 E-mail: absmgmtpantex@pantex.doe.gov
Long-Term Disability (LTD)	NY Life	Phone: 1-800-362-4462
Special Accident, Basic Life and Accidental Death and Dismemberment (AD&D), and Voluntary AD&D Insurance	Pantex Benefits Office	Phone: 1-806-573-1100 E-mail: benefitspantex@pantex.doe.gov
Group Universal Life (GUL) Insurance	MetLife	Phone: 1-800-846-0124 www.mybenefits.metlife.com
Pantex Voluntary Plans	MetLife Allstate (closed plans)	Phone: 1-800-438-6388 www.mybenefits.metlife.com www.allstateatwork.com
Long-Term Care	Prudential	Phone: 1-800-732-0416
COBRA	Allegiance Services, Inc.	Phone: 1-800-259-2738 www.askallegiance.com

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