Business Travel Accident Insurance for Staff

Members of Battelle Memorial Institute

Summary Plan Description
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Important Information

The following is a summary of the Business Travel Accident Insurance for Staff Members of Battelle Memorial Institute (the “Plan”) as of January 1, 2011. The Plan is an insured Welfare plan designed to provide you and your covered dependents with insurance for covered accidents occurring while you are on business travel for Battelle. Battelle Memorial Institute (“Battelle”) is the Plan Sponsor and Plan Administrator of the Plan.

Battelle has delegated much of the day-to-day administration of the Plan to the Plan’s third party administrator, Federal Insurance Company, a member company of The Chubb Group of Insurance Companies (“Chubb” or the “insurance carrier”). Because this is an insured plan, it is subject to certain requirements of the insurance carrier for benefits and administration. Chubb has discretionary authority to make benefit determinations under the Plan. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

The Plan is funded by insurance issued by Chubb Underwriting Office: Federal Insurance Company, 202 Hall’s Mill Road, P.O. Box 1600, Whitehouse Station, New Jersey 08889-1600.

Claims may be mailed to:

Chubb Group of Insurance Companies
Claim Service Center
600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700
Telephone: (800) 252-4670

Policy Number: 6408-06-22

This summary plan description is a written statement to inform you about the coverage, and any limitations, exclusions, and requirements that apply within the Plan.

While we have tried to describe the Plan as completely and accurately as possible, due to the relatively brief nature of this summary and the complexity of the agreements that establish and govern the Plan, some details may not have been described or have been described only briefly. Consequently, any conflicts between this summary and the actual legal Plan document will be controlled by the terms of the legal Plan document, not by this summary. Likewise, any questions about the Plan that arise from reading this summary should be resolved by referring to the actual legal Plan document. The legal document for the Plan is available for your review at the Battelle office that administers your benefits.

The extent of the coverage provided by the Plan described herein is governed at all times by the complete terms of the Plan document, including the Policy.
Purpose of the Plan

The primary purpose of the Plan is to provide you and your covered spouse or registered partner and dependent children with financial protection against covered hazards when you travel on assignment by or at the direction of Battelle. In addition, the Plan provides you access to a service organization that will assist you in locating medical care and other related services in the event of a medical emergency while on business travel.

Plan Effective Date

January 1, 2011

Eligibility

Waiting Period

There is no waiting period. Persons are covered under the Plan immediately upon entering into an eligible group.

Eligible Groups

The following are considered “Primary Covered Persons” under the Plan:

- All active employees working for an eligible employer. An “eligible employer” is Battelle Memorial Institute (including Battelle Corporate Operations, Battelle Manufacturing, and the Pacific Northwest Division), Battelle Services Company, Inc., the Battelle National Biodefense Institute, LLC, Scientific Advances, Inc., Battelle Energy U.K., LLC, and Bluefin Robotics Corporation; and
- All members of the Board of Trustees or Board of Directors of Battelle.

While the benefit under the Plan is generally intended for Primary Covered Persons as described above, the following dependents are also covered under the Plan when they accompany the Primary Covered Person on a business or relocation trip made by or at the direction of Battelle, if Battelle pays for the dependent’s travel associated expenses:

- Spouse or registered partner of a Primary Covered Person (unless the spouse or registered partner is also an enrolled staff member); and
- Dependent children of a Primary Covered Person who is under age 25 or are incapacitated.

No person covered as a Primary Covered Person can be covered as a dependent.

No person can be covered as a dependent by more than one Primary Covered Person.

Definition of Spouse and Registered Partner

A spouse is defined as the Primary Covered Person’s husband or wife or who is recognized as such by the laws of the jurisdiction in which the Primary Covered Person resides.
A registered partner is a person designated by a Primary Covered Person who is registered as a registered partner or legal equivalent under laws of the governing jurisdiction or who:

- Is at least 18 years of age and competent to enter into a contract
- Is not related to the Primary Covered Person by blood
- Has exclusively lived with the Primary Covered Person for at least 12 months prior to the date of enrollment
- Is not legally married or separated; and
- As of the date of enrollment, has with the Primary Covered Person at least two of the following financial arrangements:
  a) A joint mortgage or lease
  b) A joint bank account
  c) A joint title to or ownership of a motor vehicle or status as a joint lessee on a motor vehicle lease; or
  d) A joint credit card account with a financial institution.

Neither the Primary Covered Person nor the registered partner can be married to, nor be in a civil union with, anyone else.

You may not cover your spouse/registered partner as a dependent if your spouse/registered partner is enrolled for coverage as an employee for an eligible employer listed in the ‘Eligible Groups’ section of this document.

**Definition of Dependent Child**

Dependent child means a Primary Covered Person’s unmarried child, including natural child, grandchild, stepchild, foster child, or adopted child from the date of placement with a Primary Covered Person. The dependent child must be primary dependent upon the Primary Covered Person for maintenance and support, and must be:

- Under the age of 25; or
- Classified as an incapacitated dependent child.

An incapacitated dependent child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on a Primary Covered Person for support and maintenance. The incapacity must have occurred while the child was:

- Under the age of 19; or
- Under the age of 25 if enrolled as a full-time student at any accredited public or private college, university, professional trade or vocational school beyond the 12th grade.

An incapacitated dependent child may qualify for dependent coverage subject to medical proof of such incapacity being accepted by the insurance carrier (both at the initial application and on an ongoing basis). It is your responsibility to initiate the request to the insurance carrier. Contact the Benefits Office for applicable forms.
A dependent child may not be covered by more than one staff member for Plan purposes (e.g., for a child of married staff members.)

**Ineligible Staff Members**

You are not eligible to participate in the Plan if you do not work for an eligible employer listed in the ‘Eligible Groups’ section of this summary. In addition, individuals performing services for Battelle in any of the following categories (as determined by Battelle) are not eligible to participate in the Plan:

- Individuals treated as independent contractors
- Contractor’s employee
- Leased employee
- Union employee, except as provided in a collective bargaining agreement between the union and Battelle
- Any employee working for an eligible employer who is not paid by United States, Canadian, or British payroll.

**Enrollment**

No action is required by an employee to participate in the Plan. However, you will be required to complete a beneficiary election form. Eligible persons will be automatically enrolled and Battelle pays 100% of the cost for the coverage.

**Beneficiary Designation**

At the time you first become eligible, you should name a beneficiary on your beneficiary form. You may change your beneficiary at any time by completing a new form and returning it to your Benefits Office. The beneficiary designation will be effective as of the date you sign a new form.

It is important that you name a beneficiary and keep your designation current. The benefit amount for a covered loss of life will be paid to the beneficiary designated by a covered person. If a covered person does not name a beneficiary, the insurance carrier will make payment to the first surviving family members of the family members in the order listed below:

- The covered person’s spouse or registered partner
- In equal shares to the covered person’s surviving child or children
- In equal shares to the covered person’s surviving parents
- In equal shares to the covered person’s surviving brothers and sisters
- The covered person’s estate.

If your spouse or registered partner would like to name a beneficiary other than the order listed above, he or she should contact the Benefits Office for a spousal beneficiary form.

The Primary Covered Person shall have the sole right to designate a beneficiary for a dependent child who is a minor. Any benefit amount payable due to loss of life of a dependent child will be paid to the Primary Covered Person, absent any beneficiary designation by the dependent child.
All other benefit amounts are paid to the covered person, unless otherwise directed by the covered person.

If any beneficiary has not reached the legal age of majority, then the insurance carrier will pay such beneficiary’s legal guardian.

**Coverage Effective Dates**

Persons are covered under the Plan immediately upon entering into an eligible group.

**Coverage**

**Description of Business Travel**

Business travel, for purposes of the Plan, is traveling on assignment by or at the direction of Battelle. Business travel generally does not include your commute to and from work, unless you are traveling to and from the site of emergency work.

Coverage for business travel begins at the actual start of the trip, whether it is from Battelle’s premises or from your home or other location, whichever is last. The coverage ends upon return to your home or place of employment, whichever is first. You will also be covered while on certain side trips of a personal nature which would not have occurred, but for the business trip and are incidental to your business trip. These side trips are limited to a period of seven consecutive days. The Plan includes coverage while traveling in your personally owned or leased automobiles and while you are a passenger on a covered commercial aircraft or a covered Battelle aircraft.

The insurance applies worldwide.

**Hazards and Accidents**

A hazard means the circumstances for which this insurance is provided. Hazards include:

- 24 hour business travel
- Non-employee directors business travel hazard (traveling to, at, or returning from the Battelle board of directors’ meetings, business travel, or relocation travel, at Battelle’s authorization, direction and expense)
- Extraordinary Commutation (public transportation system discontinues due to a strike, major breakdown or catastrophe)
- Felonious Assault (loss as a result of an act of violence which occurs on Battelle premises)
- Bomb (an injury or loss caused or resulting from a bomb scare, bomb search , or bomb explosion while on Battelle premises)
- Covered activities (while traveling to and from site of emergency work, to which the covered person is assigned, by Battelle)

An accident is a sudden, unforeseen, and unexpected event which:

- Happens by chance
• Is independent of illness, disease, or other bodily malfunction or medical or surgical
treatment thereof; and
• Is the direct cause of loss.

Covered Persons

Covered persons under the Plan have been divided below into classes:

<table>
<thead>
<tr>
<th>Class</th>
<th>Description of Covered Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>All staff members working for an eligible employer</td>
</tr>
<tr>
<td>Class 2</td>
<td>All members of the Board of Trustees or Board of Directors of Battelle</td>
</tr>
<tr>
<td>Class 3</td>
<td>Spouse or registered partners of the Primary Covered Person</td>
</tr>
<tr>
<td>Class 4</td>
<td>Dependent children of the Primary Covered Person</td>
</tr>
<tr>
<td>Class 5</td>
<td>All staff members working for an eligible employer assigned to do emergency work</td>
</tr>
</tbody>
</table>

Benefit Amounts

Principle Sum

As a covered person, you are eligible for coverage under the Plan for up to $500,000, dependent
upon your class listed in the ‘Covered Persons’ section of this document. Your benefit amount is
called the “principle sum” of coverage. The principle sum for each class is listed below:

<table>
<thead>
<tr>
<th>Class</th>
<th>Principle Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$500,000</td>
</tr>
<tr>
<td>Class 2</td>
<td>$500,000</td>
</tr>
<tr>
<td>Class 3</td>
<td>$100,000</td>
</tr>
<tr>
<td>Class 4</td>
<td>$25,000</td>
</tr>
<tr>
<td>Class 5</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

Schedule of Benefits

Benefits are provided for covered losses which occur as a direct result of an accident. In general,
loss, as used in the Plan, means the types of accidental bodily injuries listed below for which the Plan
provides benefits. In order to be covered, the loss must arise out of an accident that occurs while you
are on assignment by or at the direction of Battelle, and the loss must occur within one year of the
accident. If you have more than one loss as a result of one accident, the insurance carrier will pay
only the single largest benefit amount applicable to the losses suffered. You may not receive
payment from the Plan for the same loss both as a participating staff member and as a
spouse/registered partner or dependent of another covered person.
## Accidental Death and Dismemberment

<table>
<thead>
<tr>
<th>Loss</th>
<th>Class</th>
<th>Benefit Amount (Percentage of Principle Sum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech and Loss of Hearing</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech and one of:</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>- Loss of Hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of Foot; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of Sight of One Eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of Hearing and one of:</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>- Loss of Hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of Foot; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of Sight of One Eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of Hands (Both), Loss of Feet (Both), or Loss of Sight</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>OR</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>Any combination of any two of Loss of Hand, Loss of Foot, or Loss of Sight of One Eye</td>
<td>All classes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Hand, Loss of Foot, or Loss of Sight of One Eye (any one of each)</td>
<td>All classes</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Speech or Loss of Hearing</td>
<td>All classes</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger on same hand</td>
<td>All classes</td>
<td>25%</td>
</tr>
</tbody>
</table>

To be considered a covered loss:

- **Loss of Speech** means the permanent and irrecoverable loss of capability of speech without the aid of mechanical devices as determined by a physician.
- **Loss of Hearing** means the permanent and irrecoverable loss and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a physician.
- **Loss of Hand** means complete severance through or above the knuckle joints of at least four fingers, or three fingers and a thumb, on the same hand (even if reattached)
- **Loss of Foot** means complete severance through or above the ankle joints (even if reattached)
• **Loss of Sight** means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

• **Loss of Sight of One Eye** means the permanent loss of vision in one eye. Remaining vision in that eye must be no better than 20/200 using a corrective aid or device, as determined by a physician.

• **Loss of Thumb and Index finger** means complete severance, through or above the knuckles on the same hand, as determined by a physician (even if reattached).

The Plan also provides benefits for certain “Loss of Use” benefits (as described below) that occur as a direct result of a covered accident. Loss of Use means the permanent and total inability of the specified body part to function, as determined by a physician approved by the Insurance Carrier. In order to be covered, the loss must arise out of an accident that occurs within one year of the accident. The total amount of time that must elapse before a benefit amount becomes payable is known as the elimination period. The elimination period for loss of use benefits is 30 days.

<table>
<thead>
<tr>
<th>Loss of Use</th>
<th>Class</th>
<th>Benefit Amount (Percentage of Principle Sum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Use of One Hand or One Foot</td>
<td>All classes</td>
<td>25%</td>
</tr>
<tr>
<td>Loss of Use of Both Hands or Both Feet OR A combination of One Hand and One Foot</td>
<td>All classes</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Use of One Arm or One Leg</td>
<td>All classes</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of Use of Both Arms or Both Legs OR A combination of One Arm and One Leg</td>
<td>All classes</td>
<td>75%</td>
</tr>
<tr>
<td>Loss of Use of Both Arms and Both Legs</td>
<td>All classes</td>
<td>100%</td>
</tr>
</tbody>
</table>

To be considered a covered loss:

• **Loss of Use of a Hand** must start at or above the knuckle joints of at least four fingers, or three fingers and a thumb, on the same hand.

• **Loss of Use of a Foot** must start at or above the ankle joint.
- **Loss of Use of a Arm** must start at or above the elbow joint.
- **Loss of Use of a Leg** must start at or above the knee joint.

### Additional Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Class</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma</td>
<td>All classes</td>
<td>1% per month up to the Maximum Benefits Payable (see the ‘Maximum Benefits Payable’ section of this summary)</td>
</tr>
</tbody>
</table>

**Benefit paid if:**

- Lapse into coma within 30 days after accident
- Remains in coma for 30 consecutive days; and
- Is confined to a hospital or other licensed facility to receive treatment for the coma, within the first 30 days following the accident.

**Payment ends the earliest of:**

- The covered person dies
- The covered person is no longer in a coma; or
- Total benefits equal the maximum benefits payable.

If covered person dies as a result of the accident, the insurance carrier will pay a lump sum equal to the loss of life benefit amount, less coma benefit amounts already paid.

### Medical Evacuation and Repatriation

The Plan provides benefits while you are on a covered trip when you are traveling at home or abroad for covered expenses for emergency transportation to a medical facility and/or return to your home country.

**A covered trip:**

- Is more than 100 miles from the covered person’s primary residence; and
- Lasts no more than 365 consecutive days

<table>
<thead>
<tr>
<th></th>
<th>Class</th>
<th>Maximum Benefit Amount: $500,000</th>
<th>Hospital Admission Guaranty Amount: $5,000</th>
<th>Family Travel Expense Amount: $100</th>
<th>Maximum Number of Days: 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All classes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The medical evacuation or repatriation must be:

- Ordered by a physician
- Approved by the insurance carrier

This benefit amount is payable in addition to any other applicable benefit amounts under the Plan.

If emergency medical treatment is needed, the insurance carrier will guarantee payment to the hospital up to the hospital admission guaranty amount.

If the person is confined to a hospital for more than 5 days and the hospital is more than 75 miles away from your permanent residence, the insurance carrier will arrange and pay for family travel assistance.

The hospital admission and family travel amounts are part of the total maximum benefit amount for medical evacuation or repatriation.

### Permanent Total Disability Lump Sum

The insurance carrier will pay this benefit if an accidental bodily injury causes a Primary Covered Person to suffer a permanent total disability. This benefit does not apply to persons age 70 or older on the date of the accident.

The benefit will be paid after a 365 day period of continuous permanent total disability beginning on the date of the accident.

<table>
<thead>
<tr>
<th>Class 1, 2, and 5</th>
<th>Maximum Benefit Amount: $500,000 Elimination Period – 365 days</th>
</tr>
</thead>
</table>

### Psychological Therapy

The Plan provides this benefit if an accidental bodily injury results in a physician determination that psychological therapy is required.

The benefit will be paid until the earlier of:

- The total benefit amount for

| All classes | 10% of the Principle Sum up to a Maximum Benefit Amount: $50,000. |
psychological therapy expense has been paid; or
- Two years have elapsed from the date of a covered loss.

This benefit amount is payable in addition to any other applicable benefit amounts under the Plan.

<table>
<thead>
<tr>
<th><strong>Rehabilitation Expense</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan provides this benefit if an accidental bodily injury prevents a covered person from performing all the duties of their regular occupation and requires the person to obtain rehabilitation as determined by a physician and approved by the insurance carrier.</td>
</tr>
<tr>
<td>The benefit will be paid until the earlier of:</td>
</tr>
<tr>
<td>- The total benefit amount for rehabilitation expense has been paid; or</td>
</tr>
<tr>
<td>- Two years have elapsed from the date of the accidental bodily injury.</td>
</tr>
<tr>
<td>This benefit amount is payable in addition to any other applicable benefit amounts under the Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Seat Belt</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plan provides this benefit if an accidental bodily injury results in a covered loss of life while the covered person is operating or riding in a private passenger automobile, and using a seat belt. The seat belt must have been properly secured, and used in accordance with the recommendations of its manufacture.</td>
</tr>
<tr>
<td>No benefit will be paid if the vehicle is used for a race or contest of any type.</td>
</tr>
<tr>
<td>This benefit amount is payable in addition to any other applicable benefit amounts under the Plan.</td>
</tr>
</tbody>
</table>
Extensions of Insurance

Disappearance

If a covered person has not been found within one year of the disappearance, stranding, sinking, or wrecking of a conveyance in which a covered person was an occupant at the time of the accident, then it will be assumed, subject to all other terms and conditions of the Plan, that a covered person has suffered loss of life and will be covered subject to the terms of the Plan.

Exposure

If a covered person is unavoidably exposed to the elements and as a result of such exposures suffers a loss, then such loss will be covered under the Plan.

Maximum Benefits Payable

If a covered person is eligible for insurance under multiple classes as described in the ‘Covered Persons’ section of this summary, then such person will only be covered under the class which provides the largest benefit amount for the loss that has occurred.

The maximum benefit amount payable shall not exceed the following principle sums:

<table>
<thead>
<tr>
<th>Class</th>
<th>Principle Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$500,000</td>
</tr>
<tr>
<td>Class 2</td>
<td>$500,000</td>
</tr>
<tr>
<td>Class 3</td>
<td>$100,000</td>
</tr>
<tr>
<td>Class 4</td>
<td>$25,000</td>
</tr>
<tr>
<td>Class 5</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

If a covered person has multiple losses as described in the ‘Summary of Benefits’ section of this summary, only the single largest benefit applicable to the losses suffered will be paid by the insurance carrier.

However, the following benefits will be paid in addition to maximum benefit amount:

- Medical Evacuation and Repatriation
- Psychological Therapy
- Rehabilitation Expense; and
- Seat Belt
Aggregate Limit of Insurance

If more than one covered person suffers a loss in the same accident, the insurance carrier will not pay more than the aggregate limit of insurance listed below:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Aggregate Limit of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felonious Assault Hazard</td>
<td>$ 5,000,000*</td>
</tr>
<tr>
<td>Bomb Hazard</td>
<td>$ 5,000,000*</td>
</tr>
<tr>
<td>Aircraft Accident</td>
<td>$ 15,000,000</td>
</tr>
<tr>
<td>War Risk (currently Iraq and Afghanistan, but subject to change)</td>
<td>$ 10,000,000</td>
</tr>
</tbody>
</table>

*The per hazard limits listed here is a sublimit and are a part of and not in addition to the aircraft limit.

If an accident results in benefit amounts becoming payable, which when totaled, exceed the amounts shown above, then the aggregate limit will be divided proportionally among the covered persons, based on each applicable benefit amount.

Exclusions

The Plan does not cover any loss, fatal or non-fatal caused by or resulting from:

- Intentionally self-inflicted injury.
- Suicide or attempted suicide.
- Participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.
- Incarceration after conviction.
- Emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to a covered person’s bacterial infection caused by an accident or by accidental consumption of a substance contaminated with bacteria.
- War or any act of war, whether declared or undeclared in the covered person’s jurisdiction or permanent residence, Canada, or within the United States.
- Being in, entering, or exiting any aircraft that is owned, leased, or operated on Battelle’s behalf or operated by a staff member of Battelle on Battelle’s behalf. This exclusion does not apply to owned aircraft, leased aircraft, or operated aircraft listed on file with Battelle when piloted by a certified pilot licensed to operate such aircraft. The aircraft must have an unrestricted airworthiness certificate.
- Being in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply if such covered person is certified and licensed by a governmental authority to operate or serve as crew on a Battelle owned aircraft, leased aircraft, or operated aircraft. This exclusion also does not apply to passengers who temporarily perform pilot or crew functions in a life threatening emergency.
• Commuting, unless necessary due to the discontinuance of service (for a maximum of 90 days) due to a strike or major breakdown of one or more public conveyance transportation systems you would otherwise regularly use.

Termination of Coverage

All coverage under the Plan will terminate on the earliest of the date:

• You no longer meet the eligibility criteria as described in the ‘eligible groups’ section of this summary; or
• The Plan terminates.

Fraud

Insurance under the Plan is void if the eligible employer or the covered person:

• Has intentionally concealed or misrepresented any material fact relating to the Plan before or after a loss; or
• Files a false report of a loss.

Workers’ Compensation

This Plan does not replace or affect the requirements for coverage by workers’ compensation.

Claims Procedures

If you wish to file a claim for accidental death or accidental injury benefits, you or your beneficiary should follow the claim procedures described in this summary. Written claim notice must be provided within 20 days after the occurrence or commencement of any loss covered by the Plan or as soon as reasonably possible. Notice must include enough information to identify the insured person. Failure to give claim notice within 20 days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible. If you have any questions about what to do, you should contact the insurance carrier directly. See the ‘Important Information’ section of this summary for the insurance carrier’s claim mailing address and toll free telephone number.

If a Claim is based on Accidental Death (Loss of Life)

If a claim is based on accidental death, you or your beneficiary should contact your local Benefits Office to receive a claim form. Your Benefits Office will complete the Employer’s Statement and you will be responsible for sending the completed and signed claim form and all required documents to the insurance carrier. If you do not receive the form within 15 days of the request, send the insurance carrier written proof without waiting for the form.

The following documents are required with your completed claim form:

• A certified copy of the death certificate
• Certified copies of all documents supporting claimant’s authority (e.g., Letters Testamentary, Letters of Administration, Guardianship Papers, etc.)
• Copies of all police reports, newspaper articles, etc. describing the accident.
In the case of death, the insurance carrier will have the right and opportunity to request an autopsy where not forbidden by law. Any autopsies that the insurance carrier requires will be at the insurance carrier’s expense.

**If a Claim is based on Accidental Injury (any loss other than Loss of Life)**

If a claim is based on accidental injury, you should contact your local Benefits Office to receive a claim form. Your Benefits Office will complete the Employer’s Statement and you will be responsible for sending the completed and signed claim form and all required documents to the insurance carrier. If you do not receive the form within 15 days of the request, send the insurance carrier written proof without waiting for the form.

The following documents are required with your completed claim form:

- Fully completed Attending Physician Statement (required for all claims)
- Copies of all police reports, newspaper articles, etc. describing the accident
- Copies of any additional documents that support your claim
- Copy of itemized hospital bill (In-hospital benefit only).

In the case of accidental injury, the insurance carrier will have the right and opportunity to request a covered person be examined by a physician approved by the insurance carrier, as often as reasonably necessary while a claim is open. Any examinations that the insurance carrier requires will be at the insurance carrier’s expense. You must completely cooperate with the insurance carrier with the handling of the claim, including, but not limited to timely submission of all medical and other reports and full cooperation with all physical exams. The insurance carrier also has the right to require an examination under oath. Failure to cooperate fully with the insurance carrier may result in a denial of benefits.

**Proof of Loss**

For claims involving disability, complete proof of loss (written evidence acceptable to the insurance carrier that an accident, accidental bodily injury or loss has occurred) must be given to the insurance carrier within 30 days after the loss, or as soon as reasonably possible, and in no event later than 1 year after the deadline to submit complete proof of loss, except in cases where the claimant lacks legal capacity. Subsequent written proof of the continuance of such disability must be given to the insurance carrier as determined by the insurance carrier.

For all other claims, complete proof of loss must be given to the insurance carrier within 90 days after the date of loss, or as soon as reasonably possible, and in no event later than 1 year after the deadline to submit complete proof of loss, except in cases where the claimant lacks legal capacity.

**Claim Payment**

For benefits payable involving disability, the insurance carrier will pay the covered person the applicable benefit amount monthly during the period for which the insurance carrier is liable.

For all other benefits payable under the Plan, the insurance carrier will pay the covered person or beneficiary the applicable benefit within 60 days after the insurance carrier has received complete proof of loss and the claim has been approved.
Claim Denials

In the event that your claim is denied, either in full or in part, the insurance carrier will notify you in writing within 90 days after your claim was filed. Under special circumstances, the insurance carrier is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. For claims involving disability, the initial review period for the claim is 45 days, which may be extended for up to 2 additional 30-day periods. If such an extension is required, you will receive a written notice from the insurance carrier indicating the reason for the delay and the date you may expect a final decision.

The insurance carrier’s notice of denial shall include:

- The specific reason or reasons for denial with reference to the Plan provisions on which the denial is based
- A description of any additional material or information necessary to complete the claim and why that material or information is necessary
- A description of the Plan’s procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from the insurance carrier on appeal.

Notice of the determination may be provided in written or electronic form.

Appeals

If an Appeal is Based on Death

If your authorized representative appeals a denied claim, it must be submitted in writing within 60 days after you receive the insurance carrier’s notice of denial. You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations

The insurance carrier will make a full and fair review of the claim that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The insurance carrier may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. In no event shall such extension exceed a period of 60 days from the end of the initial period. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to the insurance carrier. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to the specific Plan provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.
Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

This administrative appeal process must be completed before you begin any legal action regarding your claim.

If an Appeal is Based on Your Disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the insurance carrier determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). The insurance carrier will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the insurance carrier may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the insurance carrier and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, the insurance carrier will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, the insurance carrier will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- The specific reason(s) for the determination
- A reference to the specific Plan provision(s) on which the determination is based
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision
• The statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination

• The statement that "You or your 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."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Administrative and Contact Information

This section provides you with information about the administration of the Business Travel Accident Insurance for Staff Members of Battelle Memorial Institute.

Plan Name

Business Travel Accident Insurance for Staff Members of Battelle Memorial Institute

Plan Type

Welfare plan

Employer and Plan Sponsor

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

Employer Identification Number (EIN)

31-4379427

Plan Number

507

Plan Year

January 1- December 31
Plan Administrator

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

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

Agent for Service of Legal Process

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

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

Plan Trustee

None

Plan Amendment Procedure

Battelle reserves the right at any time to change or terminate the coverage provided under the Plan and to change any amount charged for participating in the Plan at any time and without prior notice. Any such change or termination adopted by Battelle Memorial Institute shall be on its own behalf and on behalf of each participating employer. The benefits to be provided under the Plan and the eligibility of employees members to participate in the Plan are to be determined from time to time under the then-effective provisions of the Plan instrument explaining the Plan.

Battelle has authority to amend or terminate the Plan at any time by its President or designated officer adopting a written instrument of amendment or termination or by amending or terminating the Policy. The amendment or termination of any policy funding the Plan shall automatically constitute an amendment or termination of that portion of the Plan.

Statement of ERISA Rights

As a participant in the Business Travel Accident Insurance for Staff Members of Battelle Memorial Institute, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights.

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

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

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

**Assistance with Your Questions**

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

You may also contact:

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

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