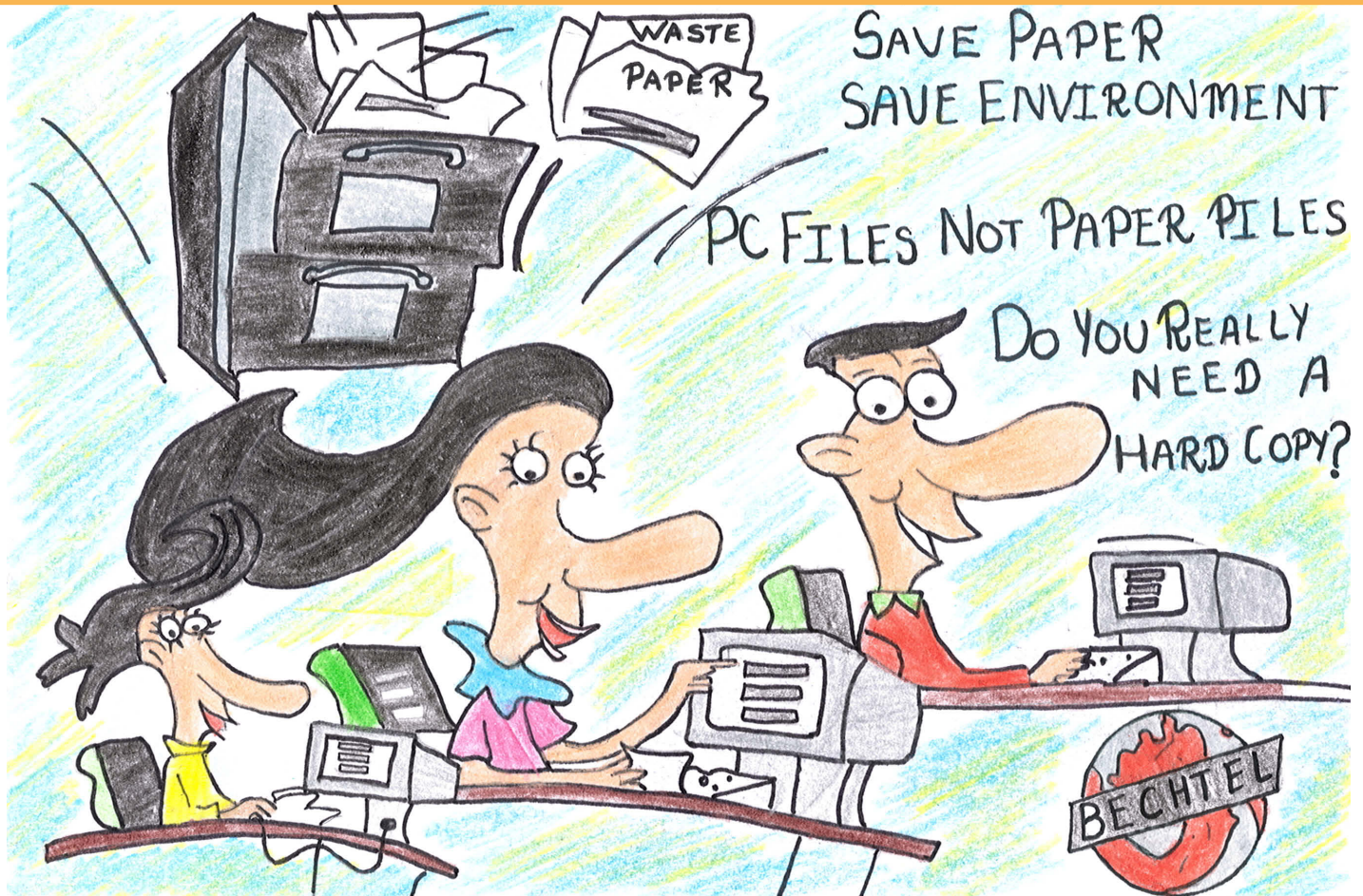




# Action Plan



## 2011 OPEN ENROLLMENT GUIDE

October 19 – November 19, 2010

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see [pages 27 through 29](#) for more details.**

For plans governed by ERISA, this 2011 Open Enrollment Guide is a Summary of Material Modifications to the Action Plan Summary Plan Description (January 2007). Keep it with your Summary Plan Description. Bechtel reserves the right to amend or discontinue any benefit plan at any time. The Plan Document(s) will govern.

You have the right to request and obtain a paper version of this document at no charge. Contact the Bechtel Employee Service Center by phone at 1-800-749-2372 or 1-602-368-1500 or by e-mail at [actben@bechtel.com](mailto:actben@bechtel.com) to request a paper version.

# Table of Contents

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Overview	2
New in 2011	3
Dependent Eligibility	4
Extension of Dependent Coverage to Age 26 for Medical, Dental and Vision	
Benefits for 2011 – Summary	6
Aetna PPO and HealthFund Summaries	8
HMO Plan Summaries	10
Medical Plan Information	14
Medco – Prescription Drug Coverage for Aetna PPO \$1,000, HealthFund and Out-of-Area Plans	
Aetna Out-of-Area Plan for Employees in the U.S.	
Medical Benefits for U.S. and Canadian International Assignees	
International Assignees Claims Processing/ID Cards	
Health Care Claims and Appeals Procedures	
Newly-Hired and Newly-Eligible Employees – Automatic Enrollment in the Aetna HealthFund	
Vision and Dental	17
Life Insurance	18
Accident Insurance	19
Disability	20
Before- or After-Tax Premiums	
Returning to Work Following Disability	
Flexible Spending Accounts	22
Health Care Spending Account (HCSA)	
Dependent Care Spending Account (DCSA)	
HCSA & DCSA are Separate Accounts	
FSA Savings	
Remember the Grace Period	
Vacation Purchase	24
Calculating the Cost of Your Vacation Purchase	
Keep in Mind	
When You Can Make Benefit Election Changes	25
Required Notices	27
Newborns' and Mothers' Health Protection	
The Women's Health and Cancer Rights Act of 1998	
Important Notice from Bechtel About Your Prescription Drug Coverage and Medicare	
Medicaid and the Children's Health Insurance Program (CHIP) offer Free or Low-Cost Health Coverage to Children and Families	
<i>myINFO</i>	32
Open Enrollment Instructions	
Making Changes to your Benefit Elections and/or Dependents	
Contact Information	34

# Overview

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Open Enrollment for 2011 benefits will run from October 19 through November 19, 2010. There are some important changes for 2011 so we encourage you to review this Open Enrollment Guide carefully. Evaluate the plans that suit you and your family best. Review your current benefit elections in *myINFO* and the plans offered for 2011, noting the changes highlighted on [page 3](#).

## **Enroll using *myINFO***

- You can make your elections at your convenience – 24/7 during the Open Enrollment period, from October 19 through November 19, 2010 (except for periods of maintenance and on payroll Mondays).
- Go to *myINFO* via the intranet (BecWeb) or the internet (Bechtel Connect).
- If you don't have changes for 2011, your current elections will remain in effect *except* for Health Care Spending Account and Dependent Care Spending Account elections, which will end December 31, 2010.
- See [page 32](#) for enrollment instructions.

Complete your new elections and/or changes by November 19, 2010, ending at 5:00pm MST (Arizona time).

Open Enrollment changes go into effect on January 1, 2011.

Generally, you may change your benefit elections only during Open Enrollment. However, you may make mid-year election changes if certain events occur and if you make the change within 31 days of the event. See [pages 25 through 26](#) for further details on changing your benefit election outside of the Open Enrollment period.

# New in 2011

	New	Change
<p><b>Dependent Child Eligible up to Age 26</b> As a result of health care reform legislation, effective January 1, 2011, eligibility for dependent children will be up to age 26. Please see <a href="#">page 4</a> for dependent eligibility rules.</p>		✓
<p><b>Premiums</b> Medical premiums for all plans are increasing. Please see <a href="#">page 6</a> for premium costs.</p>		✓
<p><b>Wellness Program Expands</b> Bechtel introduced a wellness program last year and will expand the program in 2011. You'll no longer receive wellness credits each pay period. Instead, you can earn larger wellness rewards for you and your spouse/domestic partner when you participate in wellness activities and meet healthful goals. You'll receive more details about the 2011 wellness incentives in January.</p>		✓
<p><b>HMO Eliminations</b> The following HMOs will be discontinued in 2012: Aetna-Arizona, CIGNA-Houston, Health Net, Kaiser Mid-Atlantic, and UHC-River Valley. You may want to use the U.S. Medical Plan Evaluator to help you select your medical plan for 2011 and plan your transition if you are in an HMO that will be discontinued after next year.</p>		✓
<p><b>Prescription Drug Coverage</b> There are changes to prescription drug coverage for all plans. Be sure to review the medical plan summaries on <a href="#">pages 8-13</a>.  If you enroll in the Aetna PPO \$1000, Aetna HealthFund, or Aetna Out-of-Area Plan, there are also financial consequences if you purchase your maintenance medication at a retail pharmacy instead of through <i>Medco By Mail</i> (Medco's mail-order pharmacy). Clinical management programs are also being implemented. See <a href="#">page 14</a> for details on prescription drug coverage administered by Medco.</p>		✓
<p><b>Health Care Spending Account (HCSA)</b> As a result of health care reform legislation, effective January 1, 2011, over-the-counter medicines without a prescription (other than insulin) are no longer reimbursable under HCSA. This new rule also applies to the grace period. Please see <a href="#">page 22</a> for more information about HCSA.</p>		✓
<p><b>Best Doctors</b> Best Doctors is a new, free, confidential "second-opinion" service available to all Action Plan-eligible employees and their dependents, even if you're not enrolled in a Bechtel medical plan. More information will be mailed to your home in December.</p>	✓	
<p><b>Health Care Reform – Other Changes</b> As a result of health care reform legislation, in addition to the change in dependent child eligibility, there may be changes to your medical plan. For example, HMO preventive care visits no longer require a co-payment. Be sure to review the medical plan summaries on <a href="#">pages 8-13</a>. If you have additional questions about the provisions of a specific medical plan, contact the plan directly. (Details of benefit provisions are generally covered in the HMO's Evidence of Disclosure/Evidence of Coverage). Phone numbers and Web sites of all the medical plans are on <a href="#">page 34</a>.</p>	✓	
<p><b>Short-Term and Long-Term Disability</b> During this year's Open Enrollment period, if you want to enroll in (or increase) STD and/or LTD coverage, CIGNA will allow a special shortened Evidence of Insurability Form. See <a href="#">page 20</a> for more information.</p>	✓	

# Dependent Eligibility

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Effective January 1, 2011, the following information updates and replaces the Dependent Eligibility section on page 4 of the Action Plan Summary Plan Description (January 2007).

For the medical, vision, dental and Health Care Spending Account plans, the following individuals are eligible as dependents:

## Spouse

- As legally defined by the state where employee resides.

## Domestic Partner

- As defined in the Bechtel Guidelines for U.S. Domestic Partner Benefits posted on BecWeb.

If your spouse/domestic partner is also an eligible Bechtel employee, (s)he may enroll as a dependent only if (s)he is not enrolled as an employee in that plan (e.g. medical, dental).

## Children

- Your child (biological, adopted, placed for adoption, stepchild or a child for whom you are the legal guardian) under age 26. (HMOs in some states may provide different medical coverage and/or may have different dependent eligibility rules for medical coverage. Refer to the applicable HMO Evidence of Disclosure/Evidence of Coverage.)
- Your registered domestic partner's child (biological, adopted, placed for adoption, stepchild, or a child for whom your domestic partner is the legal guardian) under age 26. (HMOs in some states may provide different medical coverage and/or may have different dependent eligibility rules for medical coverage. Refer to the applicable HMO Evidence of Disclosure/Evidence of Coverage.)

- Your fully disabled child of any age provided the child's disability begins before age 26. A child is eligible for as long as he or she is not able to earn his or her own living because of a mental or a physical disability and he or she depends chiefly on you for support and maintenance. The employee must submit certification of the child's disability to the appropriate medical plan within 3 months from the date of eligibility for coverage as a disabled dependent. Additionally, employees may be required to periodically submit proof of the child's continued disability.
- Your registered domestic partner's fully disabled child of any age provided the child's disability begins before age 26. A child is eligible for as long as he or she is not able to earn his or her own living because of a mental or a physical disability and depends chiefly on your domestic partner for support and maintenance. The employee must submit certification of the child's disability to the appropriate medical plan within 3 months from the date of eligibility for coverage as a disabled dependent. Additionally, employees may be required to periodically submit proof of the child's continued disability.
- Children pursuant to a Qualified Medical Child Support Order who also meet one of the definitions above.

A child can be enrolled as a dependent in a Bechtel plan by only one employee.

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### **Verification of Dependent Eligibility**

You may be required to provide documentation from time to time to verify your dependents' eligibility. Failure to provide satisfactory documentation may result in termination of your dependents' plan coverage. You may be required to compensate Bechtel and/or the plan for any dependent determined ineligible for coverage. Bechtel shall determine the amount of compensation to be paid. Furthermore, you may be subject to disciplinary action, up to and including termination of employment, for misrepresentations of dependent eligibility.

### **Extension of Dependent Coverage to Age 26 for Medical, Dental and Vision**

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in a medical/vision and/or the dental plan. Individuals may request enrollment for such children during the 30-day open enrollment period which runs from October 19 through November 19, 2010. Enrollment will be effective January 1, 2011.

For more information, contact the Bechtel Employee Service Center by phone at 1-800-749-2372 or 1-602-368-1500 or by e-mail at [actben@bechtel.com](mailto:actben@bechtel.com).

# Benefits for 2011 - Summary

Plan	Coverage	Cost To You (Bi-Weekly U.S. Dollars)	
<b>Medical</b>			
Aetna PPO \$1,000 Plan* <i>*If your U.S. home zip code is not in Aetna's network, <a href="#">Out-of-Area \$1,000 Plan</a> will apply.</i>	\$1,000 deductible (\$2,000 family) In-network covered expenses at 90%	Employee	\$64.30
		Employee + 1	\$120.33
		Employee + 2+	\$158.83
Aetna HealthFund	\$850 employee/\$1,700 family annual "fund" contribution \$2,000 deductible (\$4,000 family) In-network covered expenses at 80%	Employee	\$56.51
		Employee + 1	\$103.60
		Employee + 2+	\$135.80
AZ – Aetna HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$95.55
		Employee + 1	\$182.84
		Employee + 2+	\$243.22
CA – Health Net HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$84.20
		Employee + 1	\$160.14
		Employee + 2+	\$212.56
CA – Kaiser HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$103.38
		Employee + 1	\$198.38
		Employee + 2+	\$263.69
Houston Area – CIGNA HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$119.91
		Employee + 1	\$231.55
		Employee + 2+	\$308.99
Mid-Atlantic – Kaiser HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$63.64
		Employee + 1	\$112.61
		Employee + 2+	\$146.16
Mid-Atlantic – UHC Optimum Choice HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$58.39
		Employee + 1	\$106.78
		Employee + 2+	\$139.92
Eastern TN - UHC – River Valley HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$91.59
		Employee + 1	\$174.92
		Employee + 2+	\$232.51
Eastern/Western WA - Group Health Cooperative HMO	In-network covered expenses at 100% after co-payment No annual deductible	Employee	\$64.57
		Employee + 1	\$119.26
		Employee + 2+	\$156.82
<b>Vision</b>			
VSP	Automatically included with medical plan Not available as a stand alone benefit		\$0.00
<b>Dental</b>			
Aetna Dental Plan	\$50 deductible Preventive care covered expenses at 100% General care covered expenses at 80%	Employee	\$5.94
		Employee + 1	\$11.87
		Employee + 2+	\$16.02
<b>Flexible Spending Accounts</b>			
Health Care Spending Account	Set aside up to \$5,000 per year before taxes to pay for eligible health care expenses	You decide	
Dependent Care Spending Account	Set aside up to \$5,000 per year before taxes to pay for eligible dependent care expenses	You decide	

Plan	Coverage	Cost To You (Bi-Weekly U.S. Dollars)
<b>Short-Term Disability</b>		
Short-Term Basic <i>(For eligibility, and late enrollment requirements, see page 20).</i>	Annual salary up to \$93,316 Premium can be paid before or after taxes	\$0.576 per \$100 of covered salary
Short-Term Supplemental (Must enroll in Basic or have CA SDI)	Annual salary over \$93,316 up to \$216,667 Premium can be paid before or after taxes	\$0.675 per \$100 of covered salary
Supplemental for New York	Amount of covered salary up to \$93,316 Amount in excess of \$93,316 up to \$216,667	\$0.558 per \$100 of covered salary \$0.675 per \$100 of covered salary
Supplemental for New Jersey	Annual covered salary up to \$93,316 Amount in excess of \$93,316 up to \$216,667	\$0.504 per \$100 of covered salary \$0.675 per \$100 of covered salary
<b>Long-Term Disability</b>		
Long-Term Basic	Annual salary up to \$70,000 Premium can be paid before or after taxes	\$0.297 per \$100 up to first \$923.08 bi-weekly salary (\$24,000) \$0.675 per \$100 up to \$70,000 maximum
Long-Term Supplemental	Annual salary over \$70,000 up to \$220,000 Premium can be paid before or after taxes	\$0.702 per \$100 of covered salary
<b>Voluntary Personal Accident Insurance</b>	13 coverage options ranging from \$10,000 to \$500,000	Employee only – from \$0.12 to \$6.00 bi-weekly Employee & family – from \$0.18 to \$9.23 depending on coverage amounts. See <a href="#">page 19</a> for details.
<b>Vacation Purchase</b>	40 hours of vacation	(Your hourly rate x 0.70) x 40 hours
<b>Life Insurance</b>		
Basic Life Insurance	1 x annual base salary	\$0.00
<b>Company-Paid Accident Insurance</b>	1 x annual base salary (maximum \$100,000)	\$0.00
<b>Business Travel Accident Insurance</b>	5 x annual base salary (maximum \$1,000,00)	\$0.00
<b>Employee Assistance Program</b>	Up to 6 counseling sessions per situation per year	\$0.00

# Aetna PPO and HealthFund Summaries

	Aetna PPO \$1,000	Aetna HealthFund
Amounts and percentages in the table indicate the amounts/percentages that the member pays.		
Annual fund contribution	NA	\$850 per person; \$1,700 per family (Note: Fund balance maximum equal to annual out-of-pocket maximum)
Annual deductible	\$1,000 per person \$2,000 per family	\$2,000 per person; \$4,000 per family (Fund balance reduces your deductible)
Separate hospital deductible	In-network: none Out-of-network: \$300 per hospital admission	NA
Annual out-of-pocket maximum	\$5,000 per person \$10,000 per family	\$5,000 per person \$10,000 per family
Inpatient hospital <sup>1</sup> (pre-certification required in U.S., not required outside U.S.)	In-network: 10% Out-of-network: 30%; separate \$300 hospital admission deductible	In-network: 20% Out-of-network: 40%
Outpatient surgery <sup>1</sup> (pre-certification may be required)	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Doctor visits – office & hospital <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Outpatient x-rays & lab tests <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Preventive care	No charge	No charge
Maternity care – mother’s expense & newborn care <sup>1</sup>	In-network: 10% Out-of-network: 30%; separate \$300 hospital admission deductible	In-network: 20% Out-of-network: 40%
Mental health & substance use disorder – inpatient <sup>1</sup>	In-network: 10% Out-of-network: 30%; separate \$300 hospital admission deductible	In-network: 20% Out-of-network: 40%
Mental health & substance use disorder – outpatient <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Outpatient physical therapy <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Chiropractic care <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Prescription drugs (through Medco)	Network pharmacy: \$10 generic/25% brand-name formulary (maximum \$75)/ 40% brand-name non- formulary (maximum \$120) for 30-day supply; not covered at non-network pharmacy Mail-order: \$25 generic/25% brand-name formulary (maximum \$187.50)/40% brand-name non-formulary (maximum \$300.00) for 90-day supply	Network pharmacy: \$10 generic/25% brand-name formulary (maximum \$75)/ 40% brand-name non-formulary (maximum \$120) for 30-day supply; not covered at non-network pharmacy Mail-order: \$25 generic/25% brand-name formulary (maximum \$187.50)/40% brand-name non-formulary (maximum \$300.00) for 90-day supply
Prosthetic devices and durable medical equipment <sup>1</sup>	In-network: 10% Out-of-network: 30%	In-network: 20% Out-of-network: 40%
Emergency care <sup>1</sup>	Emergency care: 10% Non-emergency care: 50% Refer to Action Plan Summary Plan Description for definition of emergency care	Emergency care: 20% Non-emergency care: 50% Refer to Action Plan Summary Plan Description for definition of emergency care
Vision	Through VSP	Through VSP
Domestic partners	Covered; continuation coverage available	Covered; continuation coverage available

<sup>1</sup>Subject to annual deductible.

*International Assignees*  
**Aetna PPO \$1,000 Plan**  
*(care outside the U.S.)*

*International Assignees*  
**Aetna HealthFund**  
*(care outside the U.S.)*

NA

\$850 per person; \$1,700 per family (Note: Fund balance maximum equal to annual out-of-pocket maximum)

\$1,000 per person  
 \$2,000 per family

\$2,000 per person; \$4,000 per family  
 (Fund balance reduces your deductible)

NA

NA

\$5,000 per person  
 \$10,000 per family

\$5,000 per person  
 \$10,000 per family

20%

20%

20%

20%

20%

20%

20%

20%

No charge

No charge

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20% not subject to deductible;  
 12-month supply available at applicable  
 U.S. co-payment/co-insurance levels

20% not subject to deductible;  
 12-month supply available at applicable  
 U.S. co-payment/co-insurance levels

20%

20%

20%

20%

Through VSP

Through VSP

Covered; continuation coverage available

Covered; continuation coverage available

## When cost information helps ...

Cost may be the last thing you want to consider when you need health care. But for many common, non-emergency services, understanding what providers and facilities charge for the same service can help you save without sacrificing the quality of your care.

Check out Aetna's cost estimator tool on [Aetna Navigator](#) and compare costs. If you are enrolled in an Aetna plan, you have access to the Navigator.

# HMO Plan Summaries

	Arizona Aetna HMO	California Health Net
Annual out-of-pocket maximum	\$1,500 per person; \$3,000 per family excludes co-payments for prescription drugs	\$1,500 per person; \$4,500 per family excludes co-payments for prescription drugs and chiropractic benefits
Inpatient hospital	\$250 co-payment per admission	\$250 co-payment per admission
Outpatient surgery	\$100 co-payment	\$100 co-payment
Doctor visits – office	\$25 per visit	\$25 per visit
Doctor visits – hospital	No charge	No charge
Outpatient x-rays & lab tests	\$25 co-payment	No charge
Preventive care	No charge	No charge
Maternity care – mother’s expenses	\$25 for initial visit; no charge thereafter	\$250 hospital admission co-payment \$25 per visit in office for pre/post-natal care
Maternity care – newborn care	\$250 inpatient co-payment for delivery \$25 per visit for outpatient care	\$250 hospital admission co-payment Routine nursery care at the time of delivery is covered at 100% \$25 per visit in office
Mental health	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit
Substance use disorder	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit
Outpatient physical therapy	\$25 per visit up to 60 days (per incident of illness or injury beginning with the first day of treatment)	\$25 per authorized visit
Chiropractic care	\$25 per visit; annual maximum 20 visits	\$15 per visit; annual maximum 20 visits
Prescription drugs	\$10 generic/\$30 brand-name formulary/\$45 brand- name non-formulary for a 30-day supply Mail-order: \$20 generic/\$60 brand-name formulary/ \$90 brand-name non-formulary for a 90-day supply	Tier 1 (mostly generic) \$10/Tier 2 (mostly brand-name formulary) \$30/Tier 3 non-formulary \$45 when filled at participating pharmacy for up to a 30-day supply Mail order: Tier 1 (mostly generic) \$20/Tier 2 (mostly brand-name formulary) \$60/Tier 3 non-formulary drugs \$90 for up to a 90-day supply
Prosthetic devices and durable medical equipment	No charge	No charge
Emergency care	\$50 per emergency room visit; waived if admitted to hospital	\$50 per emergency room visit; waived if admitted to hospital
Vision	Through VSP	Through VSP
Domestic partners	Covered; continuation coverage available with restrictions	Covered; continuation coverage available

The HMO’s evidence of disclosure/evidence of coverage describes plan provisions, including claims procedures, benefits, provider network information and other plan rules in more detail. Some HMOs post their evidence of disclosure/evidence of coverage documents on their HMO Web site. You can always contact the HMO directly online or by telephone to request a copy. Additionally, you can contact the Bechtel Employee Service Center who will forward your request to the HMO. See [page 34](#) for the HMO phone number and Web site address.

### California Kaiser

\$1,500 per person; \$3,000 per family  
excludes co-payments for prescription drugs,  
chiropractic care, durable medical equipment, and  
skilled nursing facility

\$250 co-payment per admission

\$100 co-payment

\$25 per visit

No charge

No charge

No charge

\$250 hospital admission co-payment  
\$25 for initial visit  
No charge for pre-natal visits thereafter

No charge in hospital  
No charge per outpatient post-natal visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per individual visit

\$25 per authorized visit

\$15 per visit; annual maximum 20 visits

\$10 generic/\$30 brand-name per prescription filled at  
plan pharmacy for up to 30-day supply  
Mail-order: \$20 generic/\$60 brand-name per  
prescription for 100-day supply  
Mandatory formulary

No charge when prescribed by a plan physician from the  
durable medical equipment formulary

\$50 per emergency room visit;  
waived if admitted to hospital

Through VSP

Covered; continuation coverage available

### Houston Area CIGNA

\$1,000 per person; \$2,000 per family  
excludes office/outpatient visits and prescription drug  
co-payments and infertility co-insurance

\$250 co-payment per admission

\$125 co-payment

\$25 per visit

No charge

No charge

No charge

\$250 hospital admission co-payment  
\$25 for initial outpatient visit;  
no charge thereafter

\$250 hospital admission co-payment  
for inpatient care  
\$25 per visit for outpatient care

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

\$25 per visit

\$25 per visit; annual maximum 60 visits

\$10 generic/\$20 brand-name formulary/  
\$40 brand-name non-formulary per prescription  
filled at participating pharmacy for up to 30-day supply  
Mail-order: \$20 generic/\$40 brand-name formulary/  
\$80 brand-name non-formulary per prescription  
for 90-day supply

Prosthetics: No charge; \$1,000 annual maximum  
Durable medical equipment: no charge;  
\$3,500 annual maximum

\$50 per emergency room visit;  
waived if admitted to hospital

Through VSP

Covered; continuation coverage available  
with restrictions

## Compare Your Medical Options with the U.S. Medical Plan Evaluator

The U.S. Medical Plan Evaluator – our Web-based medical plan comparison tool – allows you to easily compare premium costs, as well as the comparative costs at time of treatment. It also provides information on plan features and covered services.

You can access the [Evaluator](#) any time (24/7) and from anywhere with Internet access.

Enter the following Bechtel-specific logon:

**Username:** Bechtel  
**Password:** bevaluator

If you want to save the information you have entered using the Evaluator, you'll need to save it with a unique username and password (different from those above). The information that you enter when using the Evaluator will be kept confidential and will not be shared with Bechtel or any other party.

# HMO Plan Summaries (Continued)

	Mid-Atlantic Kaiser	Mid-Atlantic UHC Optimum Choice
Annual out-of-pocket maximum	\$3,500 per person \$9,400 per family excludes co-payments for prescription drugs	\$1,100 per person \$3,600 per family excludes co-payments for prescription drugs and infertility
Inpatient hospital	\$250 co-payment per admission	\$250 co-payment per admission
Outpatient surgery	\$100 co-payment	\$100 co-payment
Doctor visits – office	\$25 per visit	\$25 per visit
Doctor visits – hospital	No charge	No charge
Outpatient x-rays & lab tests	No charge	Covered in full after applicable co-payments Refer to HMO brochure for details
Preventive care	No charge	No charge
Maternity care – mother’s expenses	\$25 for initial visit; no charge thereafter \$250 hospital admission co-payment Requires baby and mother be enrolled in Kaiser	No charge after \$250 co-payment per hospital admission Outpatient: Covered in full after applicable co-payments Refer to HMO brochure for details
Maternity care – newborn care	\$250 hospital admission co-payment Requires baby and mother be enrolled in Kaiser One post-natal visit no charge	No charge for hospitalization Outpatient: Covered in full after applicable co-payments Refer to HMO brochure for details
Mental health	In-patient: \$250 co-payment per admission Out-patient: \$25 per individual visit; \$12 per group visit	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit
Substance use disorder	In-patient: \$250 co-payment per admission Out-patient: \$25 per individual visit; \$12 per group visit	In-patient: \$250 co-payment per admission Out-patient: \$25 per visit
Outpatient physical therapy	\$25 per visit; annual maximum 30 visits	\$25 per treatment visit, for a treatment period of up to 60 visits per condition; physical, occupational and speech therapy combined limit of 60 visits per condition
Chiropractic care	\$25 per visit; annual maximum 30 visits	50%; annual maximum of \$500
Prescription drugs	\$10 generic/\$30 preferred brand-name/\$45 non-preferred brand-name for 60-day supply at Kaiser pharmacy or through mail-order \$15 for generic/\$45 preferred brand-name/\$67.50 non-preferred brand-name for 90-day supply at Kaiser pharmacy or through mail-order \$20 for generic/\$45 preferred brand-name/\$60 non-preferred brand-name for 60-day supply at a participating network pharmacy	Retail: \$10 for Tier 1, \$30 for Tier 2, \$45 for Tier 3 for up to a 31-day supply Mail-order: \$20 for Tier 1, \$60 for Tier 2, \$90 for Tier 3 for up to a 90-day supply Contact Optimum Choice for definition of Tiers
Prosthetic devices and durable medical equipment	No charge when medically necessary and authorized by plan physician	50% of charges; \$5,000 annual maximum
Emergency care	\$50 per visit; waived if admitted to hospital	\$50 per emergency treatment visit; waived if admitted to hospital
Vision	Through VSP	Through VSP
Domestic partners	Covered in states where allowed; continuation coverage available in states where allowed	Covered in states where allowed; continuation coverage not available

**Eastern Tennessee  
UHC – River Valley**

**Eastern Washington /  
Western Washington  
Group Health Cooperative**

\$1,000 per person  
\$2,500 per family  
Excludes co-payments for prescription drugs and infertility

\$1,000 per person  
\$2,000 per family  
Excludes co-payments for prescription drugs and durable medical equipment

\$250 co-payment per admission

\$250 co-payment per admission  
Ambulance covered at 80%

\$100 co-payment

\$100 co-payment

\$25 per visit

\$25 per visit

No charge

No charge

No charge

No charge

No charge

No charge

\$25 for initial visit in medical office; no charge thereafter  
No charge in hospital after \$250 admission co-payment

\$25 per visit

\$25 per visit in medical office  
No charge in hospital after \$250 admission co-payment

\$25 per visit for outpatient care  
Additional \$250 applies if newborn requires hospitalization after mother's discharge

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

In-patient: \$250 co-payment per admission  
Out-patient: \$25 per visit

\$25 per visit; annual maximum 60 visits

\$25 per visit; annual maximum 60 visits

\$25 per visit; must use network providers

\$25 per visit; annual maximum 10 visits

\$10 for generic, \$30 for brand-name on formulary,  
\$45 for brand-name non-formulary at participating  
pharmacy for up to 30-day supply  
\$20 for generic, \$60 for brand-name on formulary, \$90 for  
brand-name non-formulary for up to a 90-day supply at  
participating pharmacy or through mail-order for drugs on  
UHC River Valley 90-day supply list

\$10 for generic, \$20 for brand-name formulary/  
\$40 for brand-name non-formulary for 30-day supply  
at contracted pharmacies or through mail-order  
\$20 for generic, \$40 for brand-name formulary/  
\$80 for brand-name non-formulary for 90-day supply  
through mail-order

No charge

20%

\$50 per emergency hospital visit; waived  
if admitted to hospital; additional \$25 co-payment  
for emergency room physician care

\$50 co-payment per visit; waived if admitted  
to hospital

Through VSP

Through VSP

Covered; continuation coverage available

Covered; continuation coverage available

## Aetna HealthFund Video...

Are you confused about how the  
Aetna HealthFund plan works?  
Check the short, [15 minute video](#).

# Medical Plan Information

## Medco – Prescription Drug Coverage for Aetna PPO \$1,000, HealthFund and Out-of-Area Plans

### Changes

If you are in the Aetna PPO, Aetna HealthFund or Aetna Out-of-Area plan, there will be changes to your prescription drug coverage administered by Medco.

Medco will begin administering new clinical management programs associated with the prescription drug coverage. These programs are only for specific medications in special circumstances. If these clinical management programs impact you, Medco will contact you by mail with instructions on what you and/or your physician need to do.

### Effective January 1, 2011:

The cost for filling prescription drugs in the U.S. will be as follows:

#### Retail Pharmacy (30-day supply)

- Generic – \$10
- Brand-name on formulary – 25%, up to a maximum of \$75 per prescription
- Brand-name non-formulary – 40%, up to a maximum of \$120 per prescription

#### Medco By Mail (90-day supply)

- Generic – \$25
- Brand-name on formulary – 25%, up to a maximum of \$187.50 per prescription
- Brand-name non-formulary – 40%, up to a maximum of \$300 per prescription

If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic co-payment (\$10 retail or \$25 mail-order) **plus** the difference in cost between the brand-name drug and the generic drug, with no maximum. If you believe there are special medical circumstances that prevent you from taking the generic drug, you can request a review by calling Medco Customer Service at 1-866-544-6889.

Maintenance medications (prescription drugs that you take for chronic conditions on a long-term basis) must be purchased through *Medco By Mail*, Medco's mail-order pharmacy. You will be allowed to purchase three prescriptions for the same medication at a network retail pharmacy and pay the applicable retail co-payment or co-insurance amount. However, if you purchase additional prescriptions (i.e., more than 3) of the same medication at a network retail pharmacy, **you will pay the full cost** of the medication (that is to say, the plan won't cover any part of the cost).

There are 3 ways to start using *Medco By Mail*:

- 1) Call your physician and ask for a new 90-day supply prescription plus 3 refills that you can mail to *Medco By Mail*.
- 2) Have your physician call Medco at 1-888-327-9791 for instructions to fax a new prescription for a 90-day supply plus 3 refills.
- 3) Call Medco's customer service at 1-866-544-6889 to request that they call your physician for a new prescription that you are purchasing at retail. (Be sure to let your physician know that Medco will be calling on your behalf to avoid any confusion or delays).

### Reminder

Prescription drugs obtained from a non-network retail pharmacy will not be covered unless there is not a network pharmacy in your service area or if you have an urgent or emergency need while you are away from home and therefore cannot use a network pharmacy. You may be reimbursed for your prescription at 80% after submitting a claim to Medco. Call Medco Customer Service at 866-544-6889 for a claim form.

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## Aetna Out-of-Area Plan for Employees in the U.S.

If your U.S. home address zip code is in an area that is not covered by Aetna's network, the Aetna Out-of-Area Plan would apply. The plan generally pays 80 percent of covered expenses after you meet an annual deductible of \$1,000 (\$2,000 per family) regardless of what provider you use. Preventive care is paid at 100 percent and is not subject to the annual deductible. The Aetna Out-of-Area Plan allows you the flexibility to choose providers without a referral from a primary care physician. After reaching an annual out-of-pocket maximum, the plan pays 100 percent of eligible expenses for the remainder of the calendar year.

If you receive care from an in-network provider, the plan will pay at the in-network plan levels.

## Medical Benefits for U.S. and Canadian International Assignees

If you are on an assignment outside the United States or Canada, with a non-U.S. address, you can choose one of the following plans:

- Aetna PPO \$1,000 Plan for International Assignees
- Aetna HealthFund for International Assignees

Note: If you retain your U.S. address as your address of record and your **U. S. home zip code** is outside Aetna's PPO or HealthFund network, you will be automatically enrolled in the Aetna Out-of-Area Plan.

- If you are on an assignment outside the U.S. and you have a U.S. home zip code within an HMO service area, you may also choose an HMO. However, be aware that coverage outside the service area is for emergencies only and the determination of what constitutes an emergency is made by the HMO. If you receive non-emergency medical care outside the HMO service area, the HMO will not pay for the medical services you receive.

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## International Assignees Claims Processing/ID Cards

If you are on assignment outside the United States or Canada and you are enrolled in the Aetna PPO \$1,000 Plan, Aetna HealthFund, Aetna Out-of-Area, and/or the dental plan, Aetna Global Benefits (AGB) will process your claims. If you or your dependents receive medical care outside the United States, AGB will process claims under the international provisions of your plan. Typically, the benefit levels for medical care received outside the United States are 80 percent after the annual deductible is met. See [page 9](#) for details. If you or your dependents receive medical care in the United States (for example, while on home leave or if your dependents remain in the United States), your claims will still be processed through AGB, but under the U.S. plan provisions.

Note to employees transferring to or from an international assignment: Your ID cards and how your claims are processed are based on your assignment dates. Be sure to use the appropriate ID card when using services.

For more information about AGB, contact Aetna Global Benefits Customer Service at 1-877-676-1993 (toll-free through AT&T International) or 1-813-775-0190 (when AT&T international is not available) or e-mail [agbservice@aetna.com](mailto:agbservice@aetna.com).

## Health Care Claims and Appeals Procedures

Health care claim procedures are currently being updated to comply with the Patient Protection and Affordable Care Act (health care reform legislation) on January 1, 2011. Updated information on these new procedures for the Aetna PPO \$1000, HealthFund and Out-of-Area plans will be available within the next few months. In the interim, for information regarding non prescription-drug claims, contact Aetna Member Services by mail at Aetna, Inc., P.O. Box 14079, Lexington, KY, 40512 or by telephone at 1-800-240-4319. For information regarding prescription drug claims, contact Medco Customer Service by telephone at 1-866-544-6889. Claims information for the HMOs will be in the applicable HMO Certificate of Coverage/Evidence of Coverage document.

## Newly-Hired and Newly-Eligible Employees — Automatic Enrollment in the Aetna HealthFund

Employees hired on or after January 1, 2011 that are eligible for Action Plan benefits and employees that become eligible for Action Plan benefits on or after January 1, 2011 will have 31 days to enroll in a medical plan or elect to waive medical coverage. If the employee does not enroll in a medical plan or elect to waive medical coverage, the employee will be enrolled as "Employee Only" in the Aetna HealthFund. This coverage will remain in force until the earlier of 1) January 1 following a change made during the next Open Enrollment or 2) a change made due to a mid-year qualifying event. Employee contributions for the HealthFund will be taken from the employee's pay as a payroll deduction.

# Vision

If you enroll in a Bechtel medical plan, you and your covered dependents automatically receive vision care coverage through VSP at no charge to you. The benefits below apply if you use a VSP-network provider.

Eye exam – 1 every plan year (Jan-Dec)	\$10 co-payment Exam fully covered after the co-payment
Frames and/or lenses	\$50 co-payment, subject to plan allowance
Frame allowance – every other plan year	\$115 allowance for any frame +20% off any amount over your allowance
Prescription lenses – every plan year	Single vision, lined bifocal and lined trifocal lenses are fully covered (after \$50 materials co-payment)
Contacts –every plan year*	\$105 allowance for your contact lens exam and contacts +15% discount off cost of lens exam *If you choose contact lenses you will be eligible for a frame 24 months from the date the contact lenses were obtained.

Contact VSP by phone at 1-800-877-7195 or visit their [Web site](#) for more information on additional discounts you receive as a VSP member for frames, lenses, contacts, and laser correction surgery. Your benefits are substantially reduced if you use a non-network provider.

## Update to When Coverage Ends in the Action Plan Summary Plan Description (January 2007)

Your vision coverage ends on the same date that your medical coverage ends. If your medical coverage is continued under any extension of benefits provision, your vision coverage will also continue for the same time period. If you elect to continue your medical coverage under COBRA, your vision coverage will also continue under COBRA. The cost will be included in your COBRA premium.

Vision coverage for your covered dependent ends when your coverage ends or when (s)he no longer meets the eligibility requirements described under [Dependent Eligibility](#), whichever occurs first.

# Dental

The dental plan provides coverage for dental care expenses after payment of an annual deductible.

Preventive (e.g., cleaning, exams)	100% covered; not subject to deductible
Annual deductible	\$50 per person
General care coverage	80% of covered expenses subject to deductible
Major care coverage	50% of covered expenses subject to deductible
Maximum coverage for non-orthodontic services	\$1,750 per person
Lifetime maximum coverage for orthodontia per covered child, up to his/her 19th birthday	\$1,000 per covered child

You can receive treatment from any licensed dentist, but if you use a dentist in Aetna's network, your out-of-pocket cost will be lower because the network dentist will charge you a discounted rate. To find out if your dentist is in Aetna's dental network or to locate a network dentist, search [DocFind](#) on Aetna Navigator or call Aetna at 1-800-240-4319.

## Update to When Coverage Ends in the Action Plan Summary Plan Description (January 2007)

Dental coverage for your covered dependent ends when your coverage ends or when (s)he no longer meets the eligibility requirements described under [Dependent Eligibility](#), whichever occurs first.

# Life Insurance

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- 1 times annual base salary – company-paid
- You have the option of waiving coverage in excess of \$50,000. You may make this election at any time during the year, including during Open Enrollment, by completing a [Request for Change form](#) available on BecWeb.
- Coverage in excess of \$50,000 is considered “imputed income” by the IRS and is taxed. To calculate the amount of your taxable (imputed) income go to the [Excess Group Life Insurance Imputed Income Calculation form](#) on BecWeb.
- If you waive coverage over \$50,000 and later wish to increase it to one times your annual base salary, you will have to submit evidence of good health to MetLife and MetLife will have to approve the increased amount before it becomes effective. Go to the [MetLife Statement of Health form](#) on BecWeb.

**Beneficiary designation for life insurance is online.**  
**Log in to *myINFO* and go to [my Benefits>Insurance Beneficiaries](#).**

# Accident Insurance

## Company-paid Accident Insurance

- This coverage is in effect 24 hours a day, on or off the job.
- Accidental death benefit is 1 times annual base salary to a maximum of \$100,000; other covered accidental losses are a percentage of this amount.

## Business Travel Accident – Company-paid

- This coverage is in effect while traveling on Bechtel business.
- Accidental death benefit is 5 times annual base salary to a maximum of \$1,000,000; other covered accidental losses are a percentage of this amount.

## Voluntary Personal Accident Insurance

- This coverage is in effect 24 hours a day, on or off the job.
- You can supplement your Company-paid Accident Insurance by enrolling in Voluntary Personal Accident Insurance. You can enroll yourself only or yourself and your eligible dependents. If your spouse/domestic partner is also an eligible Bechtel employee, (s)he may enroll as a dependent only if (s)he is not enrolled as an employee in the plan. Additionally, a child can be enrolled as a dependent in this plan by only one employee.
- Eligibility for Voluntary Personal Accident Insurance remains unchanged. Your unmarried children are eligible up to age 24.

## Voluntary Personal Accident Insurance Coverage Options

	Coverage	Employee Only	Employee & Family	Coverage	Employee Only	Employee & Family
Coverage & bi-weekly cost to you	\$10,000	\$0.12	\$0.18	\$200,000	\$2.40	\$3.69
	\$25,000	\$0.30	\$0.46	\$250,000	\$3.00	\$4.62
	\$50,000	\$0.60	\$0.92	\$300,000	\$3.60	\$5.54
	\$75,000	\$0.90	\$1.38	\$400,000	\$4.80	\$7.38
	\$100,000	\$1.20	\$1.85	\$450,000	\$5.40	\$8.31
	\$125,000	\$1.50	\$2.31	\$500,000	\$6.00	\$9.23
	\$150,000	\$1.80	\$2.77			

**Beneficiary designation for accident insurance is online.**  
**Log in to *myINFO* and go to [my Benefits>Insurance Beneficiaries](#).**

# Disability

Short-Term Disability (STD) and Long-Term Disability (LTD) insurance provide you with income replacement if you are unable to work because of a covered illness or injury.

The STD benefit is up to 60% of covered salary to a maximum salary as shown in the table below. If you work in California (or pay California SDI premiums), New York, New Jersey, Puerto Rico or Rhode Island, you are

automatically covered by a state-mandated disability program; otherwise you are eligible for Basic STD. Depending on your salary, you may also be eligible for Supplemental STD. You must have Basic STD or state-mandated disability coverage to elect Supplemental STD. See the table below for your STD options, based on work location and coverage maximums.

STD Option	States with No Mandated Disability Coverage	California	New York/ New Jersey
Basic STD Only	Annual salary up to \$93,316	n/a Mandated state disability	n/a Mandated state disability
Basic & Supplemental STD	Annual salary over \$93,316 up to \$216,667	n/a	n/a
Supplemental STD Only	n/a	Annual salary over \$93,316 up to \$216,667	Mandated state disability and additional salary up to \$216,667

Refer to the Action Plan Summary Plan Description (January 2007) for more details on disability plans and coverage, including information on how transferring work locations affects your STD coverage.

**Evidence of Insurability Special Short Form Available during Open Enrollment**

You are eligible to enroll in STD and LTD within 31 days of your date of hire. If you wish to enroll or increase your disability coverage at any other time, you must submit a paper application (Evidence of Insurability Form) directly to CIGNA for their approval.

During this year’s Open Enrollment period, if you wish to enroll in (or increase) STD and/or LTD coverage, CIGNA will allow a special, shortened Evidence of Insurability Form that omits the initial physician information. This should make the application process simpler and reduce approval time.

After this Open Enrollment period, CIGNA will again require you to submit the longer Evidence of Insurability form.

The special, [short form](#) is available on BecWeb or by contacting the Bechtel Employee Service Center at 1-800-749-2372 or 1-602-368-1500.

Employees currently enrolled in the Basic STD/LTD plans or SDI, who become eligible for Supplemental STD and/or LTD due to a mid-year salary increase, will be notified by Benefits Administration & Services. You will have 31 days from the notification date to enroll in the Supplemental plan without having to provide evidence of insurability to CIGNA.

## Before- or After-Tax Premiums

You have the option of paying for your disability premiums (excluding state-mandated disability plans) with before-tax or after-tax dollars. If you pay with before-tax dollars and you become disabled and receive benefits, applicable federal and state taxes will be withheld from your benefit payment. If you pay with after-tax dollars, no income taxes will be withheld from your benefit payments.

The STD example below is based on an annual salary of \$60,000.

STD Cost/Benefit	Before-Tax Election	After-Tax Election
Annual Premium	\$346	\$346
Assumed federal tax rate	n/a	28%
Taxes on the income used to pay premium	\$0	\$97
STD benefit (12 weeks)	\$8,308	\$8,308
Assumed federal & state tax rate	28%	N/A
Taxes on the benefit	\$2,326	\$0
Net benefit	\$5,982	\$8,308

In this example, the tax of \$97 on the annual premium is considerably less than the

potential tax bite of \$2,326 on the disability benefit. Your choice will be based on your personal circumstances – household income, savings, tax situation, etc. You may want to discuss this with a tax advisor.

Changing your premium payment from before-tax to after-tax, or vice versa, or cancelling before-tax benefits altogether, are options that are available only during Open Enrollment. You will be able to access and submit a change form through *myINFO* to do this. You can also calculate your STD and LTD payroll deductions by using the electronic worksheet "[Calculate Your LTD/STD Payroll Deductions](#)" available on BecWeb.

## Returning to Work Following Disability

You are not required to pay disability premiums while drawing a disability benefit. Therefore, your premiums will be suspended during this period. **Be sure to check your pay stub after returning to work and call the Bechtel Employee Service Center at 1-800-749-2372 or 1-602-368-1500, if your deductions have not resumed.** This will ensure unbroken coverage and reduce the impact of any retroactive deductions.

# Flexible Spending Accounts

## Health Care Spending Account (HCSA)

HCSA allows you to set aside on a before-tax basis up to \$5,000 per year (\$192.31 bi-weekly in 2011) to pay for eligible health care expenses you and your eligible dependents incur in 2011. Examples include deductibles, co-payments, co-insurances and other costs not covered by your medical, dental or vision plan.

**Effective January 1, 2011, over-the-counter (OTC) medicines without a prescription, other than insulin, are no longer reimbursable** under HCSA. This new rule also applies to the grace period. For example, an OTC medicine purchased without a prescription after December 31, 2010 is not reimbursable from your 2010 HCSA account. You can still be reimbursed for other OTC items without a prescription that otherwise meet the definition of medical care (e.g., crutches, bandages, blood sugar testing kits).

In order to be reimbursed from your HCSA account for OTC prescriptions after January 1, 2011, send your cash register receipt, your doctor's prescription for your OTC medicine and a completed claim form to the address on the Aetna claim form located on BecWeb.

Reimbursement for domestic partner expenses through HCSA is not allowed unless your domestic partner and/or your domestic partner's child are tax-qualified dependents under IRS rules.

## How to Get HCSA Reimbursements

### Streamline Submission

If you enroll in HCSA during Open Enrollment, you will automatically be signed up for Aetna's "Streamline Submission". With Streamline Submission, Aetna will automatically process your HCSA reimbursement after processing your medical or dental claim. If you prefer to submit your HCSA expenses manually, you may cancel Streamline Submission through Aetna Navigator at [www.aetna.com](http://www.aetna.com) on or after January 1.

Employees with non-tax-qualified domestic partner dependents will not be automatically signed up for Streamline Submission; you will need to manually file a reimbursement form for all of your qualified medical expenses.

### Non-Aetna Expenses

You will need to file a Flexible Spending Account Health Care Reimbursement form for non-Aetna expenses, such as HMO co-payments (except for Aetna Arizona HMO) and vision plan charges. You can obtain the reimbursement forms on BecWeb or by calling Aetna at 1-888-238-6226 (within the United States) or 1-877-676-1993 (from most places outside the United States).

## Calculating Your HCSA Contribution

To calculate how much you might need to contribute in 2011, look at your last year's out-of-pocket expenditures and factor in any costs not covered by your medical/dental/vision plans for next year, such as an eligible elective surgery, new eye glasses or dental work.

## Dependent Care Spending Account (DCSA)

DCSA allows you to set aside money on a before-tax basis to pay for dependent care expenses (e.g., for child day care) incurred in 2011, due to your and your spouse's employment or student status. The maximum amount you can contribute is \$5,000 per year (\$192.31 bi-weekly in 2011) if you're filing with the IRS as married filing jointly or as single/head of household, or \$2,500 per year (\$96.15 bi-weekly in 2011) if you're filing as married filing separately. This plan may be used for dependent day care expenses for children under age 13 or for disabled family members who qualify under IRS rules.

### How to Get DCSA Reimbursements

A Dependent Care Reimbursement form needs to be completed for all DCSA expenses. You can obtain the reimbursement forms on BecWeb or by calling Aetna at 1-888-238-6226 (within the United States) or 1-877-676-1993 (from most places outside the United States).

Reimbursement for domestic partner expenses through DCSA is not allowed unless your domestic partner and/or your domestic partner's child are tax-qualified dependents under IRS rules.

### Calculating Your DCSA Contribution

To calculate how much you might need to contribute in 2011, look at your last year's dependent care expenses and factor in expected changes.

## HCSA & DCSA are Separate Accounts

You cannot be reimbursed for HCSA expenses with unused DCSA funds or vice versa. HCSA and DCSA accounts are used for different types of expenses and thus the funds must be segregated.

## FSA Savings

**The amount you contribute to a HCSA or a DCSA will reduce your taxable compensation. The chart below shows potential savings.**

Annual FSA Amount	Bi-Weekly Contribution	Estimated Annual Tax Savings*
\$1,000	\$38.46	\$280
\$2,500	\$96.15	\$700
\$5,000	\$192.31	\$1,400

\*Assumed 28% federal tax rate.

## Remember the Grace Period

You have an additional two and a half months in 2012 to use up any money left over from your 2011 HCSA and/or DCSA contributions. These funds will be used first for any claims incurred before March 15, 2012.

You have until April 30, 2012 to request reimbursement for HCSA and/or DCSA expenses incurred from January 1, 2011 through March 15, 2012.

If you do not request reimbursement by April 30, 2012 you will forfeit the remaining 2011 balance.

# Vacation Purchase

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Vacation Purchase allows employees to “purchase” 40 hours of vacation, effective with the pay period beginning December 27, 2010. Vacation Purchase time is used before your accrued PTO (paid time off).

**If you currently participate in Vacation Purchase, your participation will continue in 2011 unless you cancel it.**

When you elect Vacation Purchase you are essentially taking 40 hours off without pay and spreading the salary loss over the year. (This reduced salary amount reduces your Trust & Thrift Plan contributions.)

Vacation Purchase is paid for through payroll deductions in equal installments on an after-tax basis over the course of the year through the last pay period ending on December 25, 2011. Deductions are based on 70% of your hourly rate of pay. Any salary increases or reductions received during the year do not affect your Vacation Purchase deduction or reimbursement.

## Calculating the Cost of Your Vacation Purchase

### Example –

- Annual Salary = \$60,000
- $\$60,000 \div 2080$  (hours in a year)  
= \$28.85 (hourly rate)
- $\$28.85 \times 70\% = \$20.20$   
(hourly Vacation Purchase cost)
- $\$20.20 \times 40$  vacation hours = \$808.00  
(annual Vacation Purchase cost)
- $\$808.00 \div 26 = \$31.08$  (biweekly deduction)

## Keep in Mind

- The payment for Vacation Purchase time is paid at 70% of your hourly rate of pay.
- If you have any unused Vacation Purchase after December 25, 2011, you will receive the remaining balance as after-tax pay.
- You can cancel Vacation Purchase mid-year only if you have not used any of it.
- If you go on holding status or a leave of absence during the year, any unused Vacation Purchase will be available for use when you return to work, and payroll deductions will resume.
- If you terminate or transfer to/from an International assignment, your Vacation Purchase will settle and you will need to authorize the appropriate deduction from your final domestic or international paycheck.

# When You Can Make Benefit Election Changes

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## **Permitted Election Changes During Open Enrollment**

You can change your benefit elections, including adding or removing dependents each year during Open Enrollment. Open Enrollment changes will go into effect on January 1 of the following year.

## **Permitted Election Changes Outside of Open Enrollment**

You are allowed to change your benefit elections outside of Open Enrollment if certain events occur and if you make the change within 31 days of the event. Generally, the event must affect eligibility and the election change must be on account of and correspond with the event.

## **Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment Rights**

### **New Dependent by Marriage, Birth, Adoption or Placement for Adoption**

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in Bechtel medical/vision coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

### **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)**

If you are declining enrollment in medical/vision coverage for yourself or your eligible dependents (including your spouse, registered domestic partner, dependent children and registered domestic partner's dependent children) because of other health insurance or group health plan coverage, you may be

able to enroll yourself and your dependents in Bechtel medical/vision coverage if you or your dependents lose eligibility for that other coverage (or if Bechtel stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after Bechtel stops contributing toward the other coverage).

### **Loss of Coverage for Medicaid or a State Children's Health Insurance Program**

If you are declining enrollment in medical/vision coverage for yourself or your eligible dependents (including your spouse, registered domestic partner, dependent children and registered domestic partner's dependent children) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in Bechtel medical/vision coverage if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' other coverage ends under Medicaid or a state children's health insurance program.

### **Eligibility for Premium Assistance from Medicaid or a State Children's Health Insurance Program**

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program, you may be able to enroll

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yourself and your dependents in Bechtel medical/vision coverage. However, you must request enrollment within 60 days after you or your dependents are deemed eligible for such assistance. For more detailed information about states that have a premium assistance program under the Children's Health Insurance Program (CHIP), please see [pages 29-31](#).

Contact the Bechtel Employee Service Center by telephone at 1-800-749-2372 or 1-602-368-1500 or by email at [actben@bechtel.com](mailto:actben@bechtel.com) for more information on special enrollment.

### **Enrolling in/Increasing Disability Coverage**

If you want to enroll in or increase your disability coverage, you may do so at any time by submitting a paper [Late Enrollment Application](#) (an Evidence of Insurability form) to CIGNA. Your application must be approved by CIGNA before coverage goes into effect.

Please note: During this year's Open Enrollment period, CIGNA has approved the use of a special, short Evidence of Insurability Form that eliminates the initial physician information requirement. This should make the application process simpler and reduce approval time. After the Open Enrollment period, CIGNA will return to requiring the longer late enrollment form.

### **Increasing Life Insurance Coverage**

If you waive coverage over \$50,000 and later wish to increase it to one times your annual base salary, you will have to submit evidence of good health to MetLife and MetLife will have to approve the increased amount before it becomes effective.

# Required Notices

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## Newborns' and Mothers' Health Protection

This notice updates and replaces the notice on page 40 of the Action Plan Summary Plan Description (January 2007).

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

State law requirements may affect newborns' and mothers' coverage under an HMO. Employees enrolled in an HMO should contact the HMO for details on this coverage.

## The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that if a group health plan provides medical and surgical benefits for mastectomies, it must also provide coverage for reconstructive surgery and prostheses following mastectomies.

The law mandates that a participant or beneficiary who is receiving benefits under the plan for a covered mastectomy, and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, co-insurance and/or co-payment provisions otherwise applicable under the plan.

## Important Notice from Bechtel About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bechtel and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare

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drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Bechtel has determined that the prescription drug coverage offered by the Bechtel Medical and Dental Plan for Employees is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan and drop your Bechtel medical coverage (which includes prescription drug coverage), be aware that you and your dependents may not be able to get this coverage back until the calendar year after the following Open Enrollment period. Remember, your current Bechtel medical coverage pays for other health expenses, in addition to prescription drugs. Contact the Bechtel Employee Service Center by telephone at 1-800-749-2372 or 1-602-368-1500, by e-mail at [actben@bechtel.com](mailto:actben@bechtel.com) or by mail at P.O. Box 7700, Glendale, AZ 85312-7700 for more information about what happens to your coverage if you join a Medicare prescription drug plan.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Bechtel and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your

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premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the Bechtel Employee Service Center by telephone at 1-800-749-2372 or 1-602-368-1500, by e-mail at [actben@bechtel.com](mailto:actben@bechtel.com) or by mail at P.O. Box 7700, Glendale, AZ 85312-7700 for further information. NOTE: You will get this notice each year and if this coverage with Bechtel changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit [Social Security](#) on the Web, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

### **Remember:**

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

## **Medicaid and the Children's Health Insurance Program (CHIP) offer Free or Low-Cost Health Coverage to Children and Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility.**

State	Website	Phone
<b>ALABAMA</b> – Medicaid	<a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a>	1-800-362-1504
<b>ALASKA</b> – Medicaid	<a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a>	(Outside of Anchorage): 1-888-318-8890 (Anchorage): 907-269-6529
<b>ARIZONA</b> – CHIP	<a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a>	1-877-764-5437
<b>ARKANSAS</b> – CHIP	<a href="http://www.arkidsfirst.com/">http://www.arkidsfirst.com/</a>	1-888-474-8275
<b>CALIFORNIA</b> – Medicaid	<a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a>	1-866-298-8443
<b>COLORADO</b> – Medicaid and CHIP	Medicaid: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> CHIP: <a href="http://www.CHPplus.org">http:// www.CHPplus.org</a>	Medicaid: 1-800-866-3513 CHIP: 303-866-3243
<b>FLORIDA</b> – Medicaid	<a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a>	1-866-762-2237
<b>GEORGIA</b> – Medicaid	<a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid	1-800-869-1150
<b>IDADO</b> – Medicaid and CHIP	Medicaid: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a> CHIP: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>	Medicaid: 1-800-926-2588 CHIP: 1-800-926-2588
<b>INDIANA</b> – Medicaid	<a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a>	1-877-438-4479
<b>IOWA</b> – Medicaid	<a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a>	1-888-346-9562
<b>KANSAS</b> – Medicaid	<a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a>	800-766-9012
<b>KENTUCKY</b> – Medicaid	<a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a>	1-800-635-2570
<b>LOUISIANA</b> – Medicaid	<a href="http://www.la.hipp.dhh.louisiana.gov">http://www.la.hipp.dhh.louisiana.gov</a>	1-888-342-6207
<b>MAINE</b> – Medicaid	<a href="http://www.maine.gov/dhhs/oms/">http://www.maine.gov/dhhs/oms/</a>	1-800-321-5557
<b>MASSACHUSETTS</b> – Medicaid and CHIP	<a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a>	1-800-462-1120
<b>MINNESOTA</b> – Medicaid	<a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance	800-657-3739
<b>MISSOURI</b> – Medicaid	<a href="http://www.dss.mo.gov/mhd/index.htm">http://www.dss.mo.gov/mhd/index.htm</a>	573-751-6944
<b>MONTANA</b> – Medicaid	<a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a>	1-800-694-3084
<b>NEBRASKA</b> – Medicaid	<a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a>	1-877-255-3092
<b>NEVADA</b> – Medicaid and CHIP	Medicaid: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> CHIP: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a>	Medicaid: 1-800-992-0900 CHIP: 1-877-543-7669

State	Website	Phone
<b>NEW HAMPSHIRE</b> – Medicaid	<a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</a>	1-800-852-3345 x 5254
<b>NEW JERSEY</b> – Medicaid and CHIP	Medicaid: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> CHIP: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>	Medicaid: 1-800-356-1561 CHIP: 1-800-701-0710
<b>NEW MEXICO</b> – Medicaid and CHIP	Medicaid: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> CHIP: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Click on Insure New Mexico	Medicaid: 1-888-997-2583 CHIP: 1-888-997-2583
<b>NEW YORK</b> – Medicaid	<a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a>	1-800-541-2831
<b>NORTH CAROLINA</b> – Medicaid	<a href="http://www.nc.gov">http://www.nc.gov</a>	919-855-4100
<b>NORTH DAKOTA</b> – Medicaid	<a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>	1-800-755-2604
<b>OKLAHOMA</b> – Medicaid	<a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>	1-888-365-3742
<b>OREGON</b> – Medicaid and CHIP	<a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a>	1-877-314-5678
<b>PENNSYLVANIA</b> – Medicaid	<a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a>	1-800-644-7730
<b>RHODE ISLAND</b> – Medicaid	<a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a>	401-462-5300
<b>SOUTH CAROLINA</b> – Medicaid	<a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a>	1-888-549-0820
<b>TEXAS</b> – Medicaid	<a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a>	1-800-440-0493
<b>UTAH</b> – Medicaid	<a href="http://health.utah.gov/medicaid/">http://health.utah.gov/medicaid/</a>	1-866-435-7414
<b>VERMONT</b> – Medicaid	<a href="http://ovha.vermont.gov/">http://ovha.vermont.gov/</a>	1-800-250-8427
<b>VIRGINIA</b> – Medicaid and CHIP	Medicaid: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a> CHIP: <a href="http://www.famis.org/">http://www.famis.org/</a>	Medicaid: 1-800-432-5924 CHIP: 1-866-873-2647
<b>WASHINGTON</b> – Medicaid	<a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a>	1-877-543-7669
<b>WEST VIRGINIA</b> – Medicaid	<a href="http://www.wvrecovery.com/hipp.htm">http://www.wvrecovery.com/hipp.htm</a>	304-342-1604
<b>WISCONSIN</b> – Medicaid	<a href="http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm">http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm</a>	1-800-362-3002
<b>WYOMING</b> – Medicaid	<a href="http://www.health.wyo.gov/healthcarefin/index.html">http://www.health.wyo.gov/healthcarefin/index.html</a>	307-777-7531

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Ext. 61565

## Open Enrollment Instructions

Review your current benefit elections in *myINFO*. You can access *myINFO* through:

- Becweb home page, look under Tools & References and click *myINFO*
- PSN Portal <http://portal.becpsn.com> under Tools & Services
- Bechtel Connect <https://connect.bechtel.com> or <https://connect.bechtel.co.uk>

Select the *myINFO* button and log in using your Bechtel Username (BUN) and password.

Select “my Benefits” on the *myINFO* home page.

Go to Step 1 on the Welcome Page and select the “Current Confirmation Report”. Review/print/save your report.

If you DO want to make changes and/or you want to enroll in a Flexible Spending Account proceed to Step 1 to begin making changes to your benefit elections and/or dependents.

If you do NOT want to make any changes to your elections or dependents and you do NOT want to enroll in a Flexible Spending Account, print or save your Open Enrollment Confirmation Report. You are now finished with this year's Open Enrollment. Remember, flexible spending accounts do not continue automatically, you must re-enroll every year.

## Making Changes to your Benefit Elections and/or Dependents

### Open Enrollment Service is Available October 19, 2010

#### Step 1.

- Access the *myINFO* site from any of the methods shown above. Enter your Bechtel UserName (BUN) and password
- Select “my Benefits” on the *myINFO* home page
- This will take you to the Welcome Page. Be sure to follow each of the following steps, as indicated.

#### Step 2.

- Review the information on record for your dependents using “**Family Members/Dependents**”. If necessary, update the information, including your dependents' Primary Care Physician (PCP) information, if you are enrolling your dependent in an HMO medical plan for the FIRST TIME. When finished, click “Overview” on the left side of the screen. If you are **removing ineligible dependents** from your plan, proceed to Step 3. The dependent(s) record will need to be unlinked. Note: You may see the names of dependents who were previously covered but are now ineligible and no longer covered under your plans. No action is required for these former dependents.
- Using the “Primary Care Physician” service, input **your** PCP information, if you are enrolling in an HMO medical plan for the FIRST TIME. When finished, click “Overview” on the left side of the screen.

### Step 3.

- Click on **“Open Enrollment”** to begin making changes to your benefit elections.
  - Click on the plan type (e.g., Medical) you want to update or enroll in from the list of available plans. If you are adding or changing a plan, click the radio button next to the plan type and select either the **“Add Plan”** or **“Edit Plan”** button. Doing so will automatically cancel the previous plan (effective December 31) as applicable.
- If you are changing plans, choose the **new plan** by clicking on the name of or the box next to the plan. Choose your coverage option by clicking on the name of or the box next to the coverage option.

**NOTE:** If you are changing plans, your coverage level and dependents will not carry over from your current plan. [You must re-enroll your dependents.](#)

  - If you are updating dependents for medical and dental plans, click on **“Select Dependents”**. Put a check mark in the box next to the dependent(s) to be covered. To remove ineligible dependents, uncheck the box next to the dependent(s) name.
- For all plans click on **“Add Plan to Selection”**.
- If you want to discontinue or waive participation in a plan, click on the radio button next to the plan type you want to stop participating in and select the **“Waive Plan”** button.

- For both the **HCSA** and **DCSA** options, you must either add or waive the plan. If you enroll in **HCSA** or **DCSA**, remember to enter the full **ANNUAL** dollar election amount – not the bi-weekly amount.
- Click on **“Review Enrollment”** to preview your plan selections after you have completed your updates.
- After reviewing your changes, click on the **“Save”** button.

### Step 4.

- Click on **“Open Enrollment Confirmation”** to print and/or save your benefit elections. If needed you can make additional changes by clicking on **“Continue Enrollment Elections”**. A confirmation statement will also be sent to your Bechtel e-mail account.

### Step 5.

- Click **“Log Off”** in the top, right corner of your screen. Do NOT simply close the window. You must log off or you could become locked out of *myINFO*.

**If you decide you want to make further changes after receiving your confirmation statement**, you have until November 19 to make changes, using the same process above.

For technical support with *myINFO*, please call Corporate Systems Application Support at: 1-866-267-7797 Option 4, Option 1 or 1-602-368-2300 Option 4, Option 1, or e-mail [csasmyfo@bechtel.com](mailto:csasmyfo@bechtel.com).

# Contact Information

## Bechtel Employee Service Center

**1-800-749-2372**

**1-602-368-1500**

**Monday through Friday from 6:00am to 4:30pm MST (Arizona time), or e-mail**

**[actben@bechtel.com](mailto:actben@bechtel.com)**

Plan	Phone	Web Site • E-Mail
Aetna PPO \$1,000 Aetna HealthFund Aetna Out-of-Area	1-800-240-4319	Aetna Navigator: <a href="http://www.aetna.com">www.aetna.com</a>
International Assignees - Aetna Global Benefits (AGB)	1-877-676-1993 (toll free through AT&T international) 1-813-775-0190 (when AT&T international is not available)	<a href="http://www.aetnaglobalbenefits.com">www.aetnaglobalbenefits.com</a> E-mail: <a href="mailto:agbservice@aetna.com">agbservice@aetna.com</a>
Medco prescription drug information for Aetna PPO/HealthFund/ Out-of-Area plans	1-866-544-6889 1-800-497-4641 (outside U.S.)	<a href="http://www.medco.com">www.medco.com</a>
AZ-Aetna HMO	1-800-726-4366	<a href="http://www.aetna.com">www.aetna.com</a>
CA – Health Net	1-800-522-0088	<a href="http://www.healthnet.com">www.healthnet.com</a>
CA – Kaiser	1-800-464-4000	<a href="http://www.kp.org">www.kp.org</a>
Houston – CIGNA HMO	1-800-244-6224	<a href="http://www.mycigna.com">www.mycigna.com</a>
Mid-Atlantic – Kaiser	1-800-777-7902	<a href="http://www.kp.org">www.kp.org</a>
Mid-Atlantic – UHC Optimum Choice	1-800-815-8958 1-800-842-2038 (Rx Member Services)	<a href="http://www.myuhc.com">www.myuhc.com</a>
TN – UHC River Valley	1-800-224-6602	<a href="http://www.uhcrv.com">www.uhcrv.com</a>
WA – Group Health Cooperative	1-888-901-4636	<a href="http://www.ghc.org">www.ghc.org</a>
Vision (VSP)	1-800-877-7195	<a href="http://www.vsp.com">www.vsp.com</a>
Dental (Aetna)	1-800-240-4319	<a href="http://www.aetna.com">www.aetna.com</a>
Flexible Spending Accounts (Aetna)	1-888-238-6226 1-877-676-1993 (outside U.S.)	<a href="http://www.aetna.com">www.aetna.com</a>
<i>myINFO</i> Technical Support Corporate Systems	1-866-267-7797 Option 4, Option 1	E-mail: <a href="mailto:csasmyfo@bechtel.com">csasmyfo@bechtel.com</a>
Application Support	1-602-368-2300 Option 4, Option 1	

Front Cover Drawing by  
Pratham Bhardwaj, Age 8  
New Delhi, India



**Bechtel Employee Service Center**

**1-800-749-2372 or 1-602-368-1500**

**Press Option 1 for Employee Benefits**