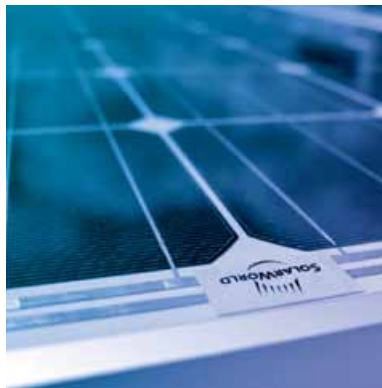


2012 Benefit Enrollment Guide



2012 BENEFIT ENROLLMENT GUIDE

WELCOME TO YOUR SOLARWORLD BENEFITS!

At SolarWorld, our employees provide the energy for our company—and together, we are working to “Build a Solar World.” Realizing this, SolarWorld has built a benefits package designed for the green collar worker—for people who seek a better life for themselves, their families and a brighter future for the world in which we all live. People dedicated and working hard to change the global picture should be rewarded with a set of options and opportunities that provide a better quality of life for themselves and their families.

As a valued SolarWorld employee, you are eligible for group and voluntary employee benefit plans aimed at providing you access to a variety of health care services, at an affordable cost, and promoting your protection and financial security against uncertain events in your life. This guide provides an overview of your benefit options to help you select the plans that will meet your individual and family needs. Please review this information carefully, and keep this guide as a reference throughout the year.

BENEFIT TYPE	OPTIONS
Medical Plans (including prescription coverage)	<ul style="list-style-type: none"> ■ Kaiser Permanente NW HMO (Oregon Based Employees Only) ■ Regence PPO ■ Regence High Deductible Health Plan (HDHP) – includes contribution by SolarWorld to a Health Savings Account (HSA)
Dental Plans	<ul style="list-style-type: none"> ■ ODS PPO Dental ■ Aetna DMO Dental
Vision Plan	<ul style="list-style-type: none"> ■ VSP Vision (Vision Service Plan)
Paid Time Off (for all regular employees)	<ul style="list-style-type: none"> ■ Vacation: 160 hours for non-exempt / Up to 5 weeks for exempt ■ Sick: 48 hours of time granted on January 1st annually ■ Holidays: 10 designated company paid holidays
401(k) Retirement Savings Plan	<ul style="list-style-type: none"> ■ Employer Match – 50% match on the first 6% contributed by employee from eligible earnings ■ 100% vested in employer match at 3 years ■ Auto Enrollment (New employees are automatically enrolled at 3% upon meeting eligibility rules)
Basic Life & AD&D Insurance	<ul style="list-style-type: none"> ■ Basic Life and Accidental Death & Dismemberment Insurance paid by the company
Flexible Spending Accounts (FSAs)	<ul style="list-style-type: none"> ■ Health Care FSA through pre-tax payroll contributions ■ Dependent Care FSA through pre-tax payroll contributions ■ Limited Purpose FSA (For HDHP/HSA Employees only)
Disability Insurance	<ul style="list-style-type: none"> ■ Short Term Disability pays 60% of base earnings up to 90 days ■ Long Term Disability pays 60% of base earnings after 90 days
Voluntary Life, Accident and Critical Illness	<ul style="list-style-type: none"> ■ Group Supplemental Life insurance for employees and dependents ■ Group Accident and Critical Illness insurance for employees and dependents
Wellness Programs	<ul style="list-style-type: none"> ■ Incentives to support our employees healthy lifestyles, including discounted gym memberships and wellness credits for participation
Education Assistance Program	<ul style="list-style-type: none"> ■ 100% education reimbursement that pays tuition and fees for approved courses or degreed programs
Solar2U	<ul style="list-style-type: none"> ■ Solar2U Employee Sunkits program to help employees install solar technology on their homes
Employee Referral Bonus	<ul style="list-style-type: none"> ■ Eligible employees receive a bonus for referring employees to work at SolarWorld

ELIGIBILITY AND COVERAGE INFORMATION

All regular employees scheduled to work 30 or more hours per week are eligible to participate in SolarWorld benefit plans. You may also enroll eligible dependents including:

- Your legal spouse
- Eligible domestic partner (additional documentation required)
- Your dependent children, your step-children, and your enrolled domestic partner's children under age 26
- Your disabled children age 26 or older who rely on you for support and care
- Any other child, who lives with you in a parent-child relationship, depends on you for support and for whom you are the court-appointed legal guardian

There are additional federal and state tax implications of enrolling domestic partners in employer health plans including taxable imputed income and taxable payroll contributions. If you are enrolling an eligible domestic partner, you will need to request a copy of the SolarWorld Enrollment Guide for Domestic Partners and complete the required documentation.

MAKING CHANGES DURING THE YEAR

Changes in coverage, including dropping coverage, adding or removing dependents are limited to Open Enrollment or experiencing a qualifying “status event” (as defined by the IRS). Enrollment changes due to qualifying status events outside of the annual Open Enrollment period should be directed to HR Services. If you experience any of the following events below you are eligible for a special enrollment.

Qualifying status events include:

- Your marriage, divorce or legal separation
- The birth, adoption, or placement for adoption of an eligible child
- The death of your spouse or covered child
- A change in your or your spouse's work status that affects benefits eligibility
- A change in residence or work location that affects your coverage (for example, moving out of the Kaiser service area)
- A change in your child's eligibility for benefits
- Becoming eligible for Medicare or Medicaid during the plan year, and/or becoming eligible or losing eligibility for domestic partner status according to our policy



You have thirty (30) days (or sixty (60) days, under certain circumstances) from the date of the qualifying status event to make changes to your benefit elections. Changes are effective on the first of the month following completion of these steps:

1. Notify HR Services as soon as possible about your status event
2. Make changes to your benefit elections
3. Provide any required documentation and forms to HR Services within the time allowed

If you wait beyond 30 days (60 days, under certain circumstances), you will not be able to make the change until the next open enrollment period.

YOUR MEDICAL OPTIONS

These days it's more important than ever to understand your health care choices. So take the time to look at the options and make the right choice for your personal situation. Making good, informed decisions about your care—from choosing the plan that meets your health care needs to discussing treatment options with your care providers—is essential to getting the most out of every health care dollar you spend.

When you consider your medical plan choices, look beyond the per-pay-period cost and seriously consider whether you're getting the coverage you actually need.

Choosing a Plan

SolarWorld provides you with the flexibility of choosing from different medical plan options. Here are the types of medical plans offered:

Health Maintenance Organization – HMO

Kaiser Permanente NW

An HMO health plan maintains an exclusive network of providers from which you may choose. You may select a primary care physician (PCP) and obtain referrals to see specialists. These plans typically do not have deductibles and services are paid for with fixed co-payments. There is no coverage for providers outside of the HMO network (except for emergencies).

Preferred Provider Organization – PPO

Regence PPO

A PPO health plan offers a network of contracted providers from which you may choose. Selecting in-network providers allows for the maximum level of benefit and coverage. You may choose out-of-network providers but it will generally cost you more. There will be a deductible to meet, then coinsurance (for example, they pay 80% of your hospital visit after your deductible is met and you pay the remaining 20%). There are also co-payments for some services.

High-Deductible Health Plan – HDHP

Regence HDHP

An HDHP is similar to a PPO, but with a high deductible. Preventative care and some preventive prescriptions are covered before meeting the deductible. Enrolling in a HDHP makes you eligible to open a Health Savings Account (HSA). An HSA is similar to an IRA in that you may contribute money to the account pre-tax and the funds can be used at any time for eligible medical expenses. HSAs are more fully explained later in this booklet.

HEALTH PLAN DEFINITIONS

Deductible – The amount of money for covered services that you must pay each year before the insurance company begins to pay its designated percentage of claims.

Co-payment – Co-payment or co-pay is a fixed dollar amount that you pay for a covered service regardless of how much the provider bills the insurance company, such as \$20 for an office visit. Typically, you do not need to meet the deductible for these covered services.

Coinsurance – The cost sharing arrangement that determines how much you pay for covered services after you meet the annual deductible. A typical coinsurance level is 80/20, which means that after you have met the plan's deductible the insurance will pay 80% of the eligible expenses and you will pay the remaining 20%.

Out-of-Pocket Maximum – This provision sets a limit on your potential costs per year. Typically, your deductible and coinsurance amounts are counted toward the maximum but co-pays are not. After you meet the plan's out-of-pocket maximum, the plan will pay 100% of eligible expenses for the remainder of the calendar year. You will still be responsible for any co-pays.

Generic – An FDA-approved drug composed of the same chemical formula as a brand-name drug.

Pre-existing condition – A medical condition for which you have been treated within 6 months prior to being covered by our plans (may be covered if certificate of creditable coverage from prior plan is provided). Note: This provision does not apply to anyone 19 or under in 2012.

CREDITABLE COVERAGE

SolarWorld medical plans offered through Regence impose a pre-existing condition exclusion. This means that if you have a medical condition before your plan coverage begins, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to anyone 19 or younger, pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. NOTE: There is not a pre-existing condition exclusion under the Kaiser plan.

The exclusion may last up to 6 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of more than 63 days. To reduce the exclusion period by your creditable coverage, you should provide a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior coverage, HR will help you obtain one from your prior plan.



MEDICAL PLANS – CHART FOR COMPARISON

PLAN FEATURES	KAISER NW HMO	REGENCE PPO (CATEGORY 1-2-3)	REGENCE HDHP W/ HSA OPTION (CATEGORY 1-2-3)
Availability	Selected locations (Oregon-based employees)	All states	All states
Deductible	None	\$500 Individual \$1,500 Family	\$1,500 employee only \$3,000 employee & family
Co-insurance	None	80% - 60% - 60%	80% - 60% - 60%
Out-of-pocket max (Individual/Family)	\$1,500/\$3,000	\$2,500/\$7,500	\$3,000/\$6,000
Physician office visit	\$20 co-pay	\$20 co-pay; \$35 co-pay; 60%	80% - 60% - 60%
Special visit	\$20 co-pay	\$20 co-pay; \$35 co-pay	80% - 60% - 60%
Preventative visit	100%	100% - 100% - 60%, deductible waved for categories 1 & 2	100% - 100% - 60%
Diagnostic x-ray & lab	\$20 co-pay	First \$600 at 100%* then 80% - 60% - 60%	80% - 60% - 60%
Urgent care	\$20 co-pay	\$20 co-pay; \$35 co-pay; 60%	80% - 60% - 60%
Emergency room	\$100 co-pay	\$100 co-pay then 80%	80%
Inpatient hospital	\$500 co-pay per admit	80% - 60% - 60%	80% - 60% - 60%
Outpatient surgery	\$50 co-pay	80% - 60% - 60%	80% - 60% - 60%
Ambulance	\$100 co-pay	80%	80%
Alternative care	Chiropractic care \$20 co-pay/15 visits	Acupuncturists, chiroprac- tors & naturopaths 80%	Not covered
Prescription drugs			
Generic	\$10	\$10	80%
- Preferred Brand	\$25	\$30	
- Non-Preferred Brand	n/a	\$60	
- Mail Order 90 Days	\$20/\$50 co-pay	\$30/\$90/\$180	

* Categories 1 & 2 only

DENTAL PLAN OPTIONS

Caring for your teeth and keeping your smile healthy can help ensure the rest of your body stays healthy as well. All SolarWorld employees are eligible to choose from two dental plan options. Dental plans are “stand-alone” plans, so you may enroll in dental coverage whether or not you are enrolled in a SolarWorld medical plan.

ODS Dental PPO Plan

The dental PPO plan is designed to provide you with a greater level of coverage for using service providers within the ODS/Delta dental network. ODS is new this year and provides a broader network of dentists. Coverage is available outside the network; however you may find that you will pay more out of pocket.

Aetna Dental DMO Plan

You also have the option of choosing the DMO dental plan which provides benefits in a similar manner to an HMO medical plan. You must select a Primary Care Dentist (PCD) from within the Aetna network to coordinate all your dental care. If your PCD believes you need to visit a dental specialist, he or she will refer you to one in the DMO network for services. There is no coverage for providers outside the DMO network. Visit www.aetna.com to choose a PCD.

DENTAL PLAN FEATURES	AETNA DMO (YOU PAY)	ODS PPO (PLAN PAYS)
Calendar year maximum	None	\$2000
Calendar year deductible	\$0	\$50 individual/\$150 family
Primary care dentist required	Yes	No
Referrals needed	Yes	No
Office visit	\$15 co-pay	See below
Preventive services (exam, x-rays, cleaning)	\$15 co-pay	PPO = 100%, Non-PPO = 90%
Basic Services (fillings, extractions, oral surgery)	Per schedule	PPO = 80%, Non-PPO = 70%
Major services (crowns, bridges, dentures)	Per schedule	PPO = 50%, Non-PPO = 50%
Orthodontic services	\$1,545 co-pay	50% up to \$1,500 lifetime maximum

VISION PLAN

Under the vision plan, you have the choice of using a VSP network doctor or a non-VSP provider. It is to your advantage to use a VSP network doctor because covered services are provided to you at a higher benefit and you will have lower out-of-pocket costs. When you wish to receive services from a VSP network doctor, simply contact the doctor and make your appointment. VSP will then provide benefit authorization to the doctor. There are no ID cards issued for the vision plan. Just identify yourself as a SolarWorld employee when you call and VSP will take care of the rest.

VISION PLAN FEATURES	IN-NETWORK (YOU PAY)	OUT-OF-NETWORK (PLAN PAYS)
Vision exam (once every 12 months)	\$25 co-pay	Up to \$50
Lenses (once every 12 months)	\$25 co-pay Basic single, bifocal or trifocal 30% off upgrades	Up to \$50 for single lenses Up to \$75 for bifocal lenses Up to \$100 for trifocal lenses
Frames (once every 12 months)	\$180 allowance for frames; 20% off the amount over your allowance	Up to \$70
Contact lenses (once every 12 months)	\$60 allowance instead of eyeglasses (covers exams, fitting, & evaluation); \$150 allowance for contacts	Up to \$105 allowance instead of eyeglasses (covers lenses, fitting & evaluation)
Laser vision correction	Discounts of 5-15% on procedures	
Extra savings	20% off extra pair of eyeglasses or sunglasses	



FLEXIBLE SPENDING ACCOUNTS (FSA)

With FSAs, you can use pre-tax dollars to pay for eligible health and dependent care expenses, tax-free. By using pretax dollars to pay for health and dependent care expenses, you are lowering your taxable income and thereby saving money. There are three different plans:

- The **Health Care FSA** is used for eligible out-of-pocket Health Care costs. Eligible expenses include: co-payments, deductibles, co-insurance, over-the-counter medications (only if prescribed by your physician), chiropractic care, laser eye surgery, orthodontic fees, etc.
- The **Dependent Care FSA** is for eligible dependent care expenses such as licensed child care, before and after school care, and caregivers for a disabled dependent living with you while you work. You can choose to contribute to the FSA plan or plans that meet your needs.
- If you enroll in the HDHP, you may elect the **Limited Purpose FSA** which can be used to reimburse out-of-pocket dental and vision expenses, only.

Here's how the plans work:

1. You decide how much you want to contribute to the FSA plan for the year (up to the plan maximum).
2. Your contributions are then taken out of your pay in equal amounts each pay period before taxes are deducted.
3. You receive eligible medical or dependent care services and receive a receipt or bill or you use your FSA Debit Card to pay for health care and/or dependent care expenses at participating locations. Always save your receipts for debit card charges in case you are asked for additional claim documentation.
5. If you file a claim, you will receive your approved tax-free reimbursement within a week. You have the option of having your reimbursement deposited directly into your bank account for even faster processing.

You cannot use Health Care FSA dollars to pay for dependent care expenses and vice versa. Each of these accounts is independent of one another.

IRS RULES: FSAs are subject to the IRS “use it or lose it” rule. This means that if you contribute more to your FSA than you use, you forfeit any money left in your account at the end of the year. Be sure to estimate your expenses carefully and be conservative when deciding how much to contribute.

Don't let the use it or lose it rule keep you from participating and reducing your tax bill. Use the FSA Election Calculator provided on MySolar HR to help you determine your contribution.

FSA	ANNUAL CONTRIBUTION LIMITS (PER PAY PERIOD)	ELEGIBLE EXPENSES*
Health Care	\$50 min (\$1.92) \$3,500 max (\$134.62)	Health care expenses not covered by insurance: <ul style="list-style-type: none"> ■ Co-pays ■ Deductibles ■ Coinsurance ■ Over-the-counter medications (with a prescription) ■ Additional services and supplies not covered by insurance
Limited Purpose (must be enrolled in the HDHP)	\$50 min (\$.92) \$3,500 max (\$134.62)	Dental and vision expenses only: <ul style="list-style-type: none"> ■ Co-pays ■ Deductibles ■ Coinsurance ■ Over-the-counter medications (with a prescription) ■ Additional services and supplies not covered by insurance
Dependent Care	\$50 min (\$1.92) \$5,000 max \$2,500 max (\$96.15) if married filing jointly	Dependent care while you're at work, including: <ul style="list-style-type: none"> ■ Daycare ■ After-school programs ■ Care in your home

HEALTH SAVINGS ACCOUNT (HSA)

What is a Health Savings Account?

A Health Savings Account (HSA) is an account that can be funded with your tax-exempt dollars to help pay for eligible medical expenses including the deductible, co-pays, and coinsurance.

Advantages of an HDHP with HSA?

- *Affordability* – You can lower your health insurance premiums by switching to health insurance coverage with a higher deductible.
- *Security* – Your high deductible insurance plan with a HSA can help protect you against high or unexpected medical bills.
- *Flexibility* – You can use the funds in your account to pay for current medical expenses, including expenses that your insurance may not cover. You may also save the money in your account for future needs, for example medical expenses after retirement.

Employees who choose to enroll in the Regence HDHP are eligible to receive SolarWorld contributions to their HSA at Chase Bank. If your Chase HSA account is open, you can receive an annual contribution of up to \$750 for employee only coverage or \$1,500 for family coverage in the HDHP. HSA contributions will be prorated during the year and made each pay period to eligible accounts. You do not need to make your own HSA contributions in order to receive the contribution from SolarWorld.

Please review the plan summary on the Chase HSA website (www.chase.com/hsa) for specific information on the eligibility requirements and benefit advantages of enrolling in the Regence \$1,500 HDHP and opening a Chase HSA.

LIFE INSURANCE OPTIONS

Your family depends on your income for a comfortable lifestyle and the resources necessary to make their dreams—such as a college education—a reality. Like anyone, you do not like to think of a scenario where you're no longer there for your family. However, it is important that you take time now to make sure you have the right coverage for your personal situation.

Basic Term Life and Accidental Death & Dismemberment Coverage

SolarWorld provides every regular employee working 30 or more hours per week with both:

- Basic term life insurance equal to two times your annual earnings (salary or base hourly rate times 2,080 hours) up to a maximum of \$750,000.
- Basic accidental death and dismemberment (AD&D) insurance equal to two times your annual earnings up to a maximum of \$750,000.

Life Insurance and Income Taxes

SolarWorld pays for your Basic Life and AD&D insurance. The cost of any coverage exceeding \$50,000 is considered “imputed income” by the IRS. Imputed income will be reported each pay period on your paycheck as part of your taxable income.

Supplemental Coverage Options

In addition to the basic coverage SolarWorld provides, you can purchase supplemental life coverage under our group policy with The Standard. You have the option to purchase:

- Supplemental Life Insurance coverage for yourself in increments of \$10,000, up to a maximum of 5 times your annual earnings or \$500,000 (whichever is less);
- Supplemental Life Insurance coverage for your spouse or domestic partner in increments of \$5,000, up to a maximum of your total basic and supplemental coverage amounts or \$500,000 (whichever is less)
- Supplemental Life Insurance coverage for your children in the amount of \$10,000.

You pay the full cost for all supplemental coverage, which may be subject to approval based on Evidence of Insurability. You can also purchase supplemental accident coverage under our group policy with The Standard which will pay a benefit if your death is due to accidental causes rather than disease or illness. You have the option to purchase either:

- Supplemental AD&D Insurance for yourself only, or
- Supplemental AD&D Insurance for your family including your spouse (or domestic partner) and your children.

Supplemental AD&D may be purchased in increments of \$25,000, up to a maximum of \$500,000. Your spouse's benefit (if enrolled) is equal to 100% of your coverage amount. Your child's benefit is equal to 10% of your coverage amount.

Basic and Supplemental AD&D coverage will provide benefit payments for certain partial losses such as a hand or foot or your sight.

Decline Reason for Elected Life Insurance

Election in this plan is voluntary. You may elect coverage for this plan at any time during the plan year. For new coverage elected 30 days after your original hire date you will be considered a “late enrollee” and coverage amounts will be subject to providing a satisfactory evidence of insurability form. If you experience a Qualifying Life Event some of the evidence requirements may be waived.

Decline reason for AD&D plans

Election in this plan is voluntary. You may elect coverage for this plan at any time during the plan year.

DISABILITY INSURANCE

SolarWorld provides all regular employees working 30 or more hours per week with disability insurance that can provide you with income in the event you are ill or disabled and cannot work. This coverage is provided at no cost to you.

Short-Term Disability (STD) Insurance

To protect your income when you can't work due to a temporary disability, STD insurance provides you with 60 percent of your weekly earnings (reduced by other income you may receive). Your STD benefits become payable on the eighth day of your disability due to an accident or illness and will continue for up to 90 days.

Long-Term Disability (LTD) Insurance

If you are not able to return to work after 90 days on STD, LTD insurance provides you with 60 percent of your monthly earnings (reduced by other income you may receive) for as long as you remain disabled according to the plan or until age 65 or longer. The maximum benefit period is determined by your age at the time of your disability.

OTHER VOLUNTARY BENEFITS

SolarWorld is providing all regular employees working 30 or more hours per week with the opportunity to purchase additional coverage to help offset their out-of-pocket medical expenses in the event of an unforeseen illness or injury.

Group Accident Insurance

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact, which can absorb your savings if you are not prepared.

Voluntary accident insurance provides benefits for covered injuries and specified accident-related expenses for an individual or family. Since health insurance only covers certain expenses (and plan limits can apply), this individual policy is designed to help cover the out-of-pocket expenses that result from a covered accident.

The plan covers a wide variety of injuries and accident-related expenses such as:

- Hospitalization
- Physical Therapy
- Hospital Intensive Care
- Transportation
- Lodging for Family

Plan Features:

- Benefits are paid for accidents that occur, so you have 24-hour coverage.
- You can also elect to cover your spouse and children.
- There are no health questions or physical exams required.
- Your coverage is individually owned, which means you can take your policy with you if you retire or leave the company.

GROUP ACCIDENT RATES

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Per Pay Period	\$5.22	\$9.46	\$10.16	\$12.16

Outpatient Physicians Treatment

Pays benefit shown for each visit by a covered person to a doctor, outside of a hospital, for any reason. This benefit is payable a maximum of two times in a calendar year per covered person, not to exceed 4 times per year for Individual and Spouse Coverage.

Individual and Child(ren) Coverage or Family Coverage

Your benefits counselor can give you detailed information on the plan and costs during your enrollment session. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations in some states. The policy has exclusions and limitations which may affect any benefits payable.

Group Critical Illness Insurance

Would your finances survive a critical illness? Group Critical Illness Insurance pays a lump sum benefit when you are diagnosed with a critical illness. You can use the benefits however you please, such as for medical bills, a wheelchair, your mortgage or other bills.

You choose the level of coverage with benefit amounts of \$10,000, \$20,000 or \$30,000. During this open enrollment, you are eligible to purchase this coverage for yourself on a guarantee issue basis (no medical underwriting). Your spouse and children, if you elect family coverage, are covered at 50% of your benefit amount.

Benefits

Benefits are paid directly to you, unless assigned, when you are diagnosed with the following critical illnesses:

- Heart Attack 100%
- Stroke 100%
- Major Organ Transplant 100%
- End-Stage Renal Failure 100%
- Coronary Artery By-pass Surgery 25%
- Invasive Cancer 100%
- Carcinoma in Situ 25%
- Advanced Alzheimer's Disease 25%
- Advanced Parkinson's Disease 25%
- Benign Brain Tumor 100%
- Coma 100%
- Complete Blindness 100%
- Complete Loss of Hearing 100%
- Paralysis 100%

Also automatically included in your plan:

Wellness Benefit

\$50 is paid per calendar year per covered person if a covered health screening test is performed, including:

- Biopsy for skin cancer
- Mammograms
- Stress test on bike or treadmill
- Electrocardiogram
- Echocardiogram
- Blood test for triglycerides
- Chest X-Ray
- Colonoscopy
- Plus many more...

Group critical Illness Rates

\$10,000 FACE AMOUNT

Age on 1/1/12	Non-Smoker				Smoker			
	EE	EE+SP	EE + CH	EE + FAM	EE	EE + SP	EE + CH	EE + FAM
18-29	\$3.66	\$5.56	\$3.66	\$5.56	\$5.66	\$8.54	\$5.66	\$8.54
30-35	\$3.68	\$5.58	\$3.68	\$5.58	\$5.70	\$8.60	\$5.70	\$8.60
36-39	\$8.54	\$12.86	\$8.54	\$12.86	\$14.06	\$21.14	\$14.06	\$21.14
40-50	\$8.68	\$13.06	\$8.68	\$13.06	\$14.30	\$21.52	\$14.30	\$21.52
51-54	\$18.16	\$27.28	\$18.16	\$27.28	\$30.08	\$45.18	\$30.08	\$45.18
55-60	\$18.62	\$27.98	\$18.62	\$27.98	\$30.88	\$46.36	\$30.88	\$46.36
61-63	\$29.66	\$44.54	\$29.66	\$44.54	\$45.48	\$68.26	\$45.48	\$68.26
64-70	\$44.44	\$66.72	\$44.44	\$66.72	\$68.32	\$102.52	\$68.32	\$102.52
71 +	\$45.46	\$68.26	\$45.46	\$68.26	\$69.94	\$104.98	\$69.94	\$104.98

\$20,000 FACE AMOUNT

Age on 1/1/12	Non-Smoker				Smoker			
	EE	EE+SP	EE + CH	EE + FAM	EE	EE + SP	EE + CH	EE + FAM
18-29	\$6.28	\$9.48	\$6.28	\$9.48	\$10.26	\$15.46	\$10.26	\$15.46
30-35	\$6.32	\$9.54	\$6.32	\$9.54	\$10.34	\$15.56	\$10.34	\$15.56
36-39	\$16.02	\$24.08	\$16.02	\$24.08	\$27.06	\$40.66	\$27.06	\$40.66
40-50	\$16.30	\$24.50	\$16.30	\$24.50	\$27.56	\$41.40	\$27.56	\$41.40
51-54	\$35.26	\$52.94	\$35.26	\$52.94	\$59.12	\$88.72	\$59.12	\$88.72
55-60	\$36.20	\$54.34	\$36.20	\$54.34	\$60.70	\$91.12	\$60.70	\$91.12
61-63	\$58.26	\$87.46	\$58.26	\$87.46	\$89.90	\$134.90	\$89.90	\$134.90
64-70	\$87.84	\$131.82	\$87.84	\$131.82	\$135.58	\$203.42	\$135.58	\$203.42
71 +	\$89.88	\$134.88	\$89.88	\$134.88	\$138.84	\$208.32	\$138.84	\$208.32

\$30,000 FACE AMOUNT

Age on 1/1/12	Non-Smoker				Smoker			
	EE	EE+SP	EE + CH	EE + FAM	EE	EE + SP	EE + CH	EE + FAM
18-29	\$8.90	\$13.40	\$8.90	\$13.40	\$14.86	\$22.36	\$14.86	\$22.36
30-35	\$8.96	\$13.50	\$8.96	\$13.50	\$14.98	\$22.52	\$14.98	\$22.52
36-39	\$23.50	\$35.30	\$23.50	\$35.30	\$40.08	\$60.16	\$40.08	\$60.16
40-50	\$23.92	\$35.94	\$23.92	\$35.94	\$40.82	\$61.28	\$40.82	\$61.28
51-54	\$52.36	\$78.60	\$52.36	\$78.60	\$88.16	\$132.28	\$88.16	\$132.28
55-60	\$53.78	\$80.72	\$53.78	\$80.72	\$90.54	\$135.86	\$90.54	\$135.86
61-63	\$86.88	\$130.38	\$86.88	\$130.38	\$134.32	\$201.54	\$134.32	\$201.54
64-70	\$131.24	\$196.92	\$131.24	\$196.92	\$202.84	\$304.32	\$202.84	\$304.32
71 +	\$134.30	\$201.50	\$134.30	\$201.50	\$207.74	\$311.68	\$207.74	\$311.68

2012 CONTRIBUTION RATES

SolarWorld is committed to offering you and your family cost-effective, quality healthcare plans. There are two primary factors that influence healthcare premiums: the inflation rate for healthcare and our utilization of those services. As we work together to find ways to improve our health by making important decisions about our lifestyles and habits, we can all benefit with lower healthcare costs and stronger, healthier lives.

SolarWorld and employee contributions will be as follows:

TYPE OF COVERAGE	SOLARWORLD CONTRIBUTION	EMPLOYEE CONTRIBUTION
Medical – HMO or PPO	80%	20%
Medical – HDHP	85%	15%
Dental	75%	25%
Vision	50%	50%

Your contributions for benefits are deducted from each paycheck on a pre-tax basis (except for domestic partner coverage):

- Medical, dental, vision and flexible spending account contributions are made before taxes are calculated. (Exception is coverage for a domestic partner.)
- Supplemental life insurance premiums and any premiums for the Voluntary Benefits (Group Critical Illness Insurance and Group Accident Insurance) are paid after your taxes are calculated.

The following tables summarize the contribution rates for the coverage you elect for 2012. All rates are per pay period (note—the medical rates shown in the table below do not reflect the \$7.69 per pay period wellness credit, or the \$6.92 per pay period tobacco surcharge).

Medical Plans	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Regence PPO plan (all locations)	\$37.57	\$87.64	\$76.05	\$115.00
Regence HDHP plan (all locations)	\$19.01	\$44.25	\$38.39	\$58.07
Kaiser Permanente HMO – NW (HBO EEs only)	\$34.55	\$80.55	\$69.84	\$105.76



Dental Plans	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
ODS PPO Plan	\$4.95	\$9.90	\$10.36	\$15.76
Aetna DMO Plan	\$3.63	\$7.08	\$7.65	\$11.66
Vision Plan	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
VSP Vision	\$1.80	\$3.60	\$3.84	\$6.14

Controlling Health Care Costs

The rising cost of health insurance is a concern for all of us. Keeping costs to a minimum contributes to lower premiums in future years. Here are tips on how you can help lower the cost of health insurance:

- Use network providers. You will receive a higher level of benefits if you use providers who participate in the network.
- Request generic rather than brand name prescription drugs. Generic medications, while just as effective, are considerably less expensive.
- Consider seeing your family physician rather than a specialist. Family physicians can often provide the same level of care for a variety of illnesses and conditions.
- Exercise and maintain a proper diet. The healthier you are the less vulnerable you are to disease, reducing doctor’s visits and prescription medicines.

If we become more aware consumers, we can each do our part to lower the cost of healthcare!

Wellness Incentives

One of the best ways to keep out-of-pocket medical costs down is to practice healthy habits. We believe employees should be rewarded for participating in programs that promote good health. SolarWorld has implemented two new programs to help encourage our employees in this practice.

Biometric Screening and Total Health Assessment

Employees who are enrolled in a SolarWorld medical plan have the opportunity to earn a \$200 per year wellness credit (\$7.69 per pay period) towards their premiums by completing two easy steps:

- *Step 1* – Participate in an annual biometric health screening—usually held during the month of November. (Watch for more details on “My Solar HR”).
- *Step 2* – Complete an online Total Health Assessment—usually held during the month of November. The Total Health Assessment is a short, confidential online questionnaire designed to measure factors that affect your health and well-being. The results give you a snapshot of your current health and recommendations for how to improve it.

Both the biometric screening and the Total Health Assessment must be completed to earn the wellness credit.

Tobacco Surcharge

There is a surcharge of \$6.92 per pay period for employees who use tobacco that are enrolled in a SolarWorld medical plan. The surcharge is in addition to the rates shown in the medical premium table.

ADDITIONAL SOLARWORLD BENEFITS

In addition to our healthcare benefit offerings, we also offer the following benefits:

- Annual TriMet passes
- Healthclub discounts
- Vantage club
- Wellness programs
- Education reimbursement
- Employee referral bonus program
- Solar2U discount program

More detailed information on these benefit programs can be found on our company intranet by logging onto “My Solar HR.”

IMPORTANT CONTACT INFORMATION

WHO TO CALL	CONTACT INFORMATION
Medical	
Regence PPO – group #60020893	(888) 367-2116 To find providers: www.regence.com (in OR/WA) www.bcbs.com (other states)
Regence HDHP – group #60020893	(877) 508-7357 To find providers: www.regence.com (in OR/WA) www.bcbs.com (other states)
Kaiser Permanente HML NW – group #16508	In Portland: (503) 813-2000 Other areas: (800) 813-2000 www.kp.org
Dental	
ODS PPO – group #10008731	(503) 265-5680 Other areas: (877) 277-7280 www.odscompanies.com
Aetna DMO – group #83005795	(877) 238-6200 www.aetna.com
Vision	
VSP – group #30-016634	(800) 877-7195 www.vsp.com
SRD, LTD, Basic and Supplemental Life Insurance	
Standard – Life and AD&D – group #148508-A	(800) 628-8600 www.standard.com
Standard – Short-term disability/Long-term disability	(866) 756-8116 www.standard.com
Critical illness and Accident Insurance	
Allstate – Case #V2073	(800) 521-3535 www.allegianceflexadvantage.com
Flexible Spending Accounts	
Allegiance Benefit Plan Management, Inc.	(877) 424-3570 www.allegianceflexadvantage.com
Health Savings Accounts	
JP Morgan Chase	(866) 566-7101 www.chasehsa.com
SolarWorld HR	
HR Services	(503) 693-5432 Email: hr.services@solarworldusa.com
Payroll	(503) 693-5270 Email: robin.nelson@solarworldusa.com

IMPORTANT LEGAL NOTICES

1. COBRA

Under certain circumstances, you and your enrolled dependents have the right to continue coverage under the medical, dental and vision plans as well as the health care flexible spending accounts, beyond the time coverage would have ordinarily ended. You may elect continuation of coverage for yourself and your dependents if you lose coverage under the plan because of one of the following qualifying events:

- Termination (for reasons other than gross misconduct)
- Reduction in employment hours to less than 30 per week
- Your entitlement to Medicare

In addition, continuation of coverage may be available to your eligible dependents if:

- You die
- You and your spouse divorce or separate
- A covered child is no longer eligible for coverage due to age or dependency status
- You become entitled to Medicare

To apply for COBRA coverage, you or a dependent must contact the SolarWorld Benefits Department within 60 days of a qualifying life event. You and/or your dependents must pay the full cost of COBRA coverage. Under the law, COBRA must be offered to eligible individuals at the same rates SolarWorld pays for active employees plus a 2 percent administrative charge. Plan rates are subject to change annually.

2. HIPAA Special Enrollment Rights

Under the special enrollment provisions of HIPAA, you may be eligible, in certain situations, to enroll in a SolarWorld medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself (and eligible dependents) if, during the year, you or your dependents have lost coverage under another plan because:

- Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage ended; or
- The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.

You must notify the plan within 30 days of the loss of coverage in order to enroll in the SolarWorld medical plan during the year. Otherwise, you will need to wait until the plan's annual open enrollment period.

If you gain a new dependent during the year as a result of birth, marriage, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the plan—again, even if you previously declined medical coverage.



You must notify the plan within 30 days of event in order to enroll in the SolarWorld medical plan during the year. Otherwise, you will need to wait until the plan's annual open enrollment period. Coverage and premiums will be retroactive to the date of the birth or adoption for children enrolled during the year under these provisions.

You will also be eligible to enroll yourself and eligible dependents if either of two events occur:

- You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
- You or your dependent qualifies for state assistance in paying your employer group medical premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in a SolarWorld medical plan. Please note that special enrollment rights allow you to either:

- Enroll in your current medical coverage; or
- Enroll in any medical plan benefit option for which you and your dependents are eligible.

3. Women's Health and Cancer Act

Under the WHCRA, any covered employee or family member who is receiving mastectomy-related benefits will be provided coverage in a manner determined in consultation with the attending physician and the patient for:

- All stages of 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 lymphedema.

These benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan.

4. Newborns and Mothers Health Protection Act

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

In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the insurance provider for prescribing a length of stay not in excess of the above periods.

5. Patient Protection Disclosure

Regence PPO Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 503-693-5432. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Regence or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator at 503-693-5432.

6. Pre-Existing Conditions Exclusion Notice

The plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before your plan coverage begins, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. The exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the exclusion period by your creditable coverage, you should give Human Resources a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, Human Resources will help you obtain one from your prior plan or issuer. There also are other ways that you can show you have creditable coverage. Please contact Human Resources if you need help demonstrating creditable coverage.

All questions about pre-existing condition exclusions and creditable coverage should be directed to the plan administrator at 503-693-5432.

7. 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, 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 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.

8. NOTICE OF CREDITABLE COVERAGE

Your Prescription Drug Coverage and Medicare

Please read this notice carefully. This notice has information about your current prescription drug coverage with SolarWorld 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 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. SolarWorld has determined that the prescription drug coverage offered by the Kaiser HMO plan, Regence PPO plan and Regence HDHP plan 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 during the annual Medicare Annual Enrollment period. 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.

REQUIRED NOTICE FROM SOLARWORLD ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

The purpose of this notice is to advise you that the prescription drug coverage (listed below) under the SolarWorld plan through Kaiser HMO and/or Regence PPO and/or Regence HDHP plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2012. This is known as "creditable coverage."

Why this is important? If you or your covered dependent(s) are enrolled in any prescription drug coverage listed in this notice during 2012 and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.