This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-844-234-7925.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $0 individual / $0 family. Out-of-network: $200 individual / $400 family. Does not apply to in-network preventive care, in-network office visits and prescription drug co-pays.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, $200 for out-of-network prescription drug coverage and for in-network paper claims, $200 for External Prosthetic Devices	You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: $7,150 individual / $14,300 family. Out-of-network: unlimited. Includes prescription drug expenses.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.myuhc.com or call 1-844-234-7925.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-844-234-7925 or visit us at www.myuhc.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-844-234-7925 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	20% co-insurance	Virtual visit - In-network $20 copay per visit by a Designated Virtual Network Provider. No coverage for out-of-network. For additional services, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$35 co-pay/visit	20% co-insurance	None
	Other practitioner office visit	$20 or $35 co-pay/visit for chiropractor	20% co-insurance	Coverage for Chiropractic services is limited to 25 days annual max.
	Preventive care/screening/immunization	No charge	20% co-insurance for Mammograms, PAPS, PSAS; otherwise not covered	Includes preventive health services specified in health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	None

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Retail: $5 co-pay Mail Order: $12 co-pay	Retail: 20% after $200 pharmacy deductible Mail Order: not covered	Retail: Covers up to a 30 day supply Mail Order: Covers up to a 90 day supply Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. Certain items identified by your plan as preventive care are covered in full and not subject to the co-pay amounts indicated.
	Preferred brand drugs	Retail: 30% co-insurance Minimum $20 co-pay, Maximum $100 co-pay Mail Order: 30% co-insurance Minimum $50 co-pay, Maximum $200 co-pay	Retail: 20% after $200 pharmacy deductible Mail Order: not covered	
	Non-preferred brand drugs	Retail: 30% co-insurance Minimum $40 co-pay, Maximum $200 co-pay Mail Order: 30% co-insurance Minimum $100 co-pay, Maximum $400 co-pay	Retail: 20% after $200 pharmacy deductible Mail Order: not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance	None
	Physician/surgeon fees	No charge	20% co-insurance	None
If you need immediate medical attention	Emergency room services	$75 co-pay/visit	$75 co-pay/visit	Per visit co pay is waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 co-pay/visit	$25 co-pay/visit	Per visit co pay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 co pay/admission	20% co-insurance	None
	Physician/surgeon fee	No charge	20% co-insurance	None

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/office visit and No charge/other outpatient services	20% co-insurance	None
	Mental/Behavioral health inpatient services	$250 co-pay/admission	20% co-insurance	None
	Substance use disorder outpatient services	$35 co-pay/office visit and No charge/other outpatient services	20% co-insurance	None
	Substance use disorder inpatient services	$250 co-pay/admission	20% co-insurance	None
If you are pregnant	Prenatal and postnatal care	No charge	20% co-insurance	None
	Delivery and all inpatient services	$250 co-pay/admission	20% co-insurance	None
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	60 days per calendar year in-network and out-of-network combined.
	Rehabilitation services	$20 or $35 co-pay/visit	20% co-insurance	20 days per calendar year in-network and out-of-network combined. Includes physical, speech and occupational therapy; cardiac, cognitive and pulmonary rehabilitation.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	No charge	20% co-insurance	60 days per calendar year in-network and out-of-network combined.
	Durable medical equipment	No charge	20% co-insurance	None
	Hospice service	No charge	20% co-insurance	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture, limitations may apply
- Bariatric surgery, limitations may apply
- Chiropractic care, limitations may apply
- Private Duty Nursing, limitations may apply
- Routine foot care, limitations may apply

The Wellness Program at the Oak Ridge National Laboratory provides various benefits, including services provided by the Health Services Division. Salaried participants may receive a reduction in medical plan premiums for participation in wellness plan activities.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-234-7925. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

Questions: Call 1-844-234-7925 or visit us at www.myuhc.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-844-234-7925 to request a copy.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: UnitedHealthcare Customer Service at 1-844-234-7925, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform, or the Department of Managed Health Care at 1-888-466-2219. Additionally, a consumer assistance program can help you file your appeal. Contact: Tennessee Department of Commerce and Insurance at 800-342-4029. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-844-234-7925.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-7925.
- Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-844-234-7925.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-7925.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,165
- **Patient pays** $375

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$285
Co-insurance	$60
Limits or exclusions	$30
Total	**$375**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,460
- **Patient pays** $940

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$140
Co-insurance	$800
Limits or exclusions	$0
Total	**$940**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.