

Indemnity Plan-Hourly: UT-Battelle, LLC.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: [01/01/2013 – 12/31/2013]

Coverage for: Individual/Individual +/Family | Plan Type: IND



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 www.myCigna.com or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$400 person / \$800 family	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. \$150 for prescription drug coverage. There are no other deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes, \$2,000 person / \$4,000 family	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?	Premium, balanced-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.	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 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	No.	You can choose any provider.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.

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Important Questions	Answers	Why this Matters:
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 .



- **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.
- Your cost sharing does not depend on whether a provided is in a network.

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	-----none-----
	Specialist visit	20% co-insurance	-----none-----
	Other practitioner office visit	20% co-insurance for chiropractor	Coverage for chiropractic services is limited to 25 days annual max.
	Preventive care/screening/immunization	No charge	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% co-insurance	-----none-----

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Common Medical Event	Services You May Need	Your cost if you use an		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	\$150 pharmacy deductible per individual, then 20% coinsurance but not less than \$10 co-pay (retail); \$15 co-pay per prescription (home delivery)	50% after \$150 pharmacy deductible (retail)/Home Delivery not covered	Covers up to 30 day supply (retail prescription); 90 days supply (mail-order prescription) 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 copay amounts indicated.
	Brand drugs	\$150 pharmacy deductible per individual, then 30% coinsurance but not less than \$10 co-pay (retail); \$35 co-pay per prescription (home delivery)	50% after \$150 pharmacy deductible (retail)/Home Delivery not covered	
Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance		—————none—————
	Physician/surgeon fees	20% co-insurance		—————none—————

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If you need immediate medical attention	Emergency room services	20% co-insurance	-----none-----
	Emergency medical transportation	20% co-insurance	-----none-----
	Urgent care	20% co-insurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	-----none-----
	Physician/surgeon fee	20% co-insurance	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	-----none-----
	Mental/Behavioral health inpatient services	20% co-insurance	-----none-----
	Substance use disorder outpatient services	20% co-insurance	-----none-----
	Substance use disorder inpatient services	20% co-insurance	-----none-----
If you are pregnant	Prenatal and postnatal care	20% co-insurance	-----none-----
	Delivery and all inpatient services	20% co-insurance	-----none-----
If you need help recovering or have other special health needs	Home health care	No charge	Coverage is limited to 60 days annual max
	Rehabilitation services	20% co-insurance	-----none-----
	Habilitation services	Not Covered	-----none-----
	Skilled nursing care	No charge	Coverage is limited to 60 days annual max
	Durable medical equipment	20% co-insurance	-----none-----
	Hospice service	20% co-insurance/ inpatient and outpatient services	-----none-----
If your child needs dental or eye care	Eye exam	Not Covered	-----none-----
	Glasses	Not Covered	-----none-----
	Dental check-up	Not Covered	-----none-----

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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**.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Children)
- Eye exam (Children)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adults)
- Routine foot care, and
- 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.)

- Chiropractic
- Infertility treatment

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.

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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 1-800-Cigna24. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

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 Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: South Carolina Consumer and Individual Licensing Services at 800-768-3467. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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

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Coverage Examples

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: \$5,700
- Plan pays \$7,540
- Patient pays \$1,840

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	\$400
Co-pays	\$40
Co-insurance	\$1,370
Limits or exclusions	\$30
Total	\$1840

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

- Amount owed to providers: \$5,400
- Plan pays \$4,070
- Patient pays 1,330

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	\$400
Co-pays	\$490
Co-insurance	\$120
Limits or exclusions	\$320
Total	\$1,330

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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.

Catalog Number:
(Indemnity Hourly Comprehensive Plan)

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