The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage contact ORNL Benefits 1-866-576-7766 or email ornlbenefits@ornl.gov. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $0 individual / $0 family. Out-of-network: $200 individual / $400 family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	In-network: $8,150 individual / $16,300 family. Out-of-network: unlimited. Includes prescription drug expenses.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of- pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover and penalties for failure to obtain Preauthorization for services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. The cost of the specialty pharmacy drugs that are considered non-essential health benefits (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-844-234-7925 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20% coinsurance	Virtual visit – In-network $20 copay by a Designated Virtual Network Provider. No coverage for out-of- network. For additional services, additional copays, deductibles, or coinsurance may apply. Convenient Care visit - In-network $20 copay. Out- of-network 20% coinsurance after deductible.
	Specialist visit	$35 copay/visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance for Mammograms, Pap Smears; otherwise not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Preauthorization is required for out-of-network sleep studies or a 20% penalty applies.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Preauthorization is required for out-of-network providers or a 20% penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 copay Mail Order: $12 copay	Retail: 50% after deductible Mail Order: not covered	Retail: Up to a 30-day supply Mail Order: 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 copay amounts indicated. Please see "Important Questions" regarding the plan's out-of-pocket limit. Specialty drugs can only be purchased through Accredo. If you choose not to enroll in SaveonSP Program you could pay the full program copay.
	Preferred brand drugs	Retail: 30% coinsurance Minimum $20 copay, Maximum $100 copay Mail Order: 30% coinsurance Minimum $50 copay, Maximum $200 copay	Retail: 50% after deductible Mail Order: not covered	
	Non-preferred brand drugs	Retail: 30% coinsurance Minimum $40 copay, Maximum $200 copay Mail Order: 30% coinsurance Minimum $100 copay, Maximum $400 copay	Retail: 50% after deductible Mail Order: not covered	
	Specialty drugs	Retail: 30% coinsurance Minimum $20 copay, Maximum $100 copay Mail Order: 30% coinsurance Minimum $50 copay, Maximum $200 copay SaveonSP Program $0 copay at Accredo	Retail: 50% after deductible Mail Order: not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Preauthorization is required for out-of-network providers or a 20% penalty applies.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Per visit copay is waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 copay/visit	$25 copay/visit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	20% coinsurance	Preauthorization is required for out-of-network providers or a 20% penalty applies.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit and No charge/other outpatient services	20% coinsurance	None
	Inpatient services	$250 copay/admission	20% coinsurance	Preauthorization is required for out-of-network providers or a 20% penalty applies.
If you are pregnant	Office visits	$35 copay initial visit	20% coinsurance	In-network routine prenatal/postnatal care covered at no charge.
	Childbirth/delivery professional services	No charge	20% coinsurance	None
	Childbirth/delivery facility services	No charge	20% coinsurance	Preauthorization is required for out-of-network providers or a 20% penalty applies. Preauthorization is also required for stays exceeding standard delivery timeframes or a 20% penalty applies.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	60 days per calendar year for out-of-network; In-network and out-of-network combined. Preauthorization is required for out-of-network providers or a 20% penalty applies.
	Rehabilitation services	$20 or $35 copay/visit	20% coinsurance	20 days per calendar year in-network and out-of-network combined. Includes physical, speech and occupational therapy; cardiac, cognitive and pulmonary rehabilitation. Preauthorization is required for out-of-network providers or a 20% penalty applies.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	No charge	20% coinsurance	60 days per calendar year in-network and out-of-network combined. Preauthorization is required for out-of-network providers or a 20% penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	20% coinsurance	Preauthorization is required for DME devices that cost more than $1000 per device (purchase or cumulative rental) and for out- of-network providers or a 20% penalty applies.
	Hospice services	No charge	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Covered up to $45	For a list of providers visit www.vsp.com or call 1-800-877-7195.
	Children's glasses	No charge for lenses. Glasses covered up to $120 allowance	Single Vision Lenses covered up to $30, Bifocals covered up to $50. Frames covered up to $70	Exams and lenses every 12 months. Frames every 24 months.
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture limited to treating nausea caused for hyperemesis of pregnancy, nausea or vomiting following chemotherapy and postoperative dental pain relief
- Bariatric surgery, prior authorization required
- Chiropractic care 25 day limit covered in-network only
- Eye care and glasses (Children) (See Page 4)
- Routine eye care (Adult). No Charge in-network, covered up to $45 out-of-network
- Routine foot care covered for services associated with foot care for diabetes and peripheral vascular disease

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: UnitedHealthCare Customer Service at 1-844-234-7925. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Tennessee Department of Commerce and Insurance at 1-800-342-4029.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$285
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$285**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$250
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1670**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$75
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$180**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: ORNL Benefits at 866-576-7766 or email ornlbenefits@ornl.gov.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination and Accessibility Requirements

This Notice applies only to UT-Battelle, LLC's group health plan and any health program that receives financial assistance from the Department of Health and Human Services

UT-Battelle, LLC (UT-Battelle) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

UT-Battelle does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- UT-Battelle:
  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact:

Deborah Bowling, Civil Rights Coordinator
P.O. Box 2008, MS 6217 Oak Ridge, TN 37831-6217
Telephone - 865-574-9846

If you believe that UT-Battelle has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Deborah Bowling, Civil Rights Coordinator
P.O. Box 2008, MS 6217, Oak Ridge, TN 37831-6217
Telephone - 865.574.9846

bowlingdm@ornl.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Deborah Bowling, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Tagline Informing Individuals with Limited English Proficiency of Language Assistance Services

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.865.574.9846.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.865.574.984 (رقم هاتف الصم والبكم).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.865.574.9846。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.865.574.9846.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.865.574.9846 번으로 전화해 주십시오.

French

ATTENTION: Si vous parlez Français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.865.574.9846.

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.865.574.9846.

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.865.574.9846.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.865.574.9846.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ: શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.865.574.9846.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1.865.574.9846 まで、お電話にてご連絡ください。

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.865.574.9846.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.865.574.9846 पर कॉल करें।

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.865.574.9846.

Persian (provided in Farsi language)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.865.574.9846 تماس بگیرید.