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, copay, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at Healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive Care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at Healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $4,000 individual / $8,000 family For out-of-network providers: $8,000 individual / $16,000 family	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?	Premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See britehr.app/OakRidge or call 1-866-683-6440 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 - $75 copay/visit	$220 copay/visit	Certain procedures performed in the office may have a higher office visit copay. Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. *Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays may apply.
	Specialist visit	$20 - $75 copay/visit	$220 copay/visit	
	Preventive care/screening/ immunization	No charge	$115 copay/visit	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	**Routine** diagnostic test (e.g., x-ray, blood work) **Non-routine** diagnostic test (e.g., sleep study, genetic testing)	**Routine** diagnostic test**:** No charge **Non-routine** diagnostic test**:** $10 - $800 copay/visit	**Routine** diagnostic test**:** No charge **Non-routine** diagnostic test**:** Up to $2,400 copay/visit	Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for certain Non-routine diagnostic tests or there may be no coverage.
	Imaging (CT/PET scans, MRIs)	$100 - $600 copay/visit	Up to $1,800 copay/visit	Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for certain imaging tests or there may be no coverage.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	**Preventive**	**Up to 90-Day Supply** No charge	Not covered	Retail Non-Maintenance: Up to a 30-day supply. Retail Maintenance New Prescription: Up to three fills of a 30-day supply. Retail and Mail Order Maintenance: Up to a 90- day supply. After three 30-day fills of a maintenance medication, if you do not fill for a 90-day supply, you will be responsible for the full cost of the medication. This cost will not apply towards your out-of-pocket maximum. Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require prior authorization. If the necessary prior authorization is not obtained, the drug may not be covered. Certain items identified by your preventive care are covered in full and not subject to the co-pay amounts indicated.
	Generic drugs	**Up to 30-Day Supply** $10 copay **Up to 90-Day Supply** $25 copay	Not covered	
	Preferred Brand drugs	**Up to 30-Day Supply** $50 copay **Up to 90-Day Supply** $125 copay	Not covered	
	Non-Preferred Brand drugs	**Up to 30-Day Supply** $75 copay **Up to 90-Day Supply** $175 copay	Not covered	
	Specialty drugs	**Up to 30-Day Supply** Generic: $50 copay Preferred: $100 copay Non-Preferred: $150 copay **Up to 90-Day Supply** Generic: $125 copay Preferred: $250 copay Non-Preferred: $375 copay SaveonSP Program $0 copay at Accredo	Not covered	Prior authorization is required for certain specialty drugs or there may be no coverage. Specialty drugs must be dispensed through Accredo. If you choose not to enroll in the SaveonSP Program, you could pay the full program copay.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 - $2,500 copay/visit	Up to $7,000 copay/visit	Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for certain outpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	$350 copay/visit	$350 copay/visit	Copay is waived if admitted within 24 hours. Out-of-network emergency room care visit copay applies to the in-network out-of-pocket limit.
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	Prior authorization is required for non-emergency medical transportation or there may be no coverage. Out-of-network emergency medical transportation copay applies to the in-network out-of-pocket limit.
	Urgent care	$35 copay/visit	$105 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 - $2,500 copay/stay	Up to $7,000 copay/stay	Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Home/Office**: $20 copay/visit **Outpatient Facility**: $75 copay/visit	**Home/Office**: $115 copay/visit **Outpatient Facility**: $225 copay/visit	Certain procedures/services in the outpatient setting may have a lower copay. Prior authorization is required for certain outpatient services or there may be no coverage.
	Inpatient services	$1,200 copay/stay	$3,600 copay/stay	Certain procedures/services in the inpatient setting may have a lower copay. Prior authorization is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	$115 copay/visit	Cost sharing does not apply to preventive services with network providers. Depending on the type of service, a copay may apply.
	Childbirth/delivery professional services	No charge	No charge	One copay for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother. Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Cost sharing does not apply to certain preventive services. Prior authorization is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage.
	Childbirth/delivery facility services	$350 - $1,600 copay/stay	$4,800 copay/stay	

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	$105 copay/visit	No visit limit for network providers and 60 visit limits for out-of-network providers per person per plan year. Prior authorization is required for certain home health care services or there may be no coverage.
	Rehabilitation services	$5 - $85 copay/visit	Up to $220 copay/visit	180 visit limit for occupational therapy, physical therapy, speech therapy, cardiac rehabilitative therapy, and pulmonary rehabilitative therapy combined. Visit limits are a combination of network providers and out-of-network providers per person per plan year. Copays are listed as a range. Providers are assigned copays within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.
	Habilitation services	$5 - $85 copay/visit	Up to $220 copay/visit	
	Skilled nursing care	$1,200 copay/stay	$3,600 copay/stay	60 day limit per person per plan year. Prior authorization is required or there may be no coverage.
	Durable medical equipment	$0 - $500 copay/equipment based on DME tier	Up to $1,000 copay/equipment based on DME tier	For durable medical equipment (DME) tiers and limitations, visit britehr.app/OakRidge website. Prior authorization is required for certain DME or there may be no coverage.
	Hospice services	**Home**: $35 copay/visit **Inpatient**: $1,600 copay/stay	**Home**: $105 copay/visit **Inpatient**: $4,800 copay/stay	None
If your child needs dental or eye care	Children's eye exam	No charge	$45 copay/visit	For a list of providers visit www.vsp.com or call 1-800-877-7195
	Children's glasses	No charges 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 plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- 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.)

- Bariatric surgery (Prior authorization required)
- Chiropractic care (25 visit limit per person per plan year for network providers)
- Hearing aids
- Infertility treatment ($20,000 lifetime maximum In-network and out-of-network combined. Lifetime maximum does not apply to diagnostic and planning services.)
- Private duty nursing
- Routine eye care (Adult)
- 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: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. You may also contact Surest Member Services at 1-866-683-6440. 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 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 on how 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: Surest Member Services at 1-866-683-6440, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **[**1-866-633-2446**]**.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 **[**1-866-633-2446**]**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **[**1-866-633-2446**]**.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf **[**1-866-633-2446**]** uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **[**1-866-633-2446**]**.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **[**1-866-633-2446**]**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **[**1-866-633-2446**]**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang **[**1-866-633-2446**]**.

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	$20 - $75
Hospital (facility) copayment	$200 - $2,500
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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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	$20 - $75
Hospital (facility) copayment	$200 - $2,500
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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$0
Specialist copayment	$20 - $75
Hospital (facility) copayment	$200 - $2,500
Other coinsurance	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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