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?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You will have to meet the deductible before the plan pays for any services.
What is the out-of-pocket limit for this plan?	In-network: $9,100 individual / $18,200 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 pre-notification 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	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	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 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.
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.

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	30%

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	30%

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	$250
Other coinsurance	30%

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	$285
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$285**

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