



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](mailto: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/](https://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                    | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0                                                                                                                                                        | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive Care</u> .                                                                                                                              | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">Healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                          |
| Are there other <u>deductibles</u> for specific services?           | No                                                                                                                                                         | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | For <u>network providers</u> :<br>\$4,000 individual / \$8,000 family<br><br>For <u>out-of-network providers</u> :<br>\$8,000 individual / \$16,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.                                                           | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="https://britehr.app/OakRidge">britehr.app/OakRidge</a> or call 1-866-683-6440 for a list of <u>network providers</u> .                   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                                         | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                                                                                                                   | In-Network Provider<br>(You will pay the least)                                                                                   | Out-of-Network Provider<br>(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 - \$75 <u>copay</u> /visit                                                                                                   | \$220 <u>copay</u> /visit                                                                                                          | <p>Certain procedures performed in the office may have a higher office visit <u>copay</u>.<br/> <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p>*Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> may apply.</p> |
|                                                        | <u>Specialist</u> visit                                                                                                                           | \$20 - \$75 <u>copay</u> /visit                                                                                                   | \$220 <u>copay</u> /visit                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                        | <u>Preventive care/screening/immunization</u>                                                                                                     | No charge                                                                                                                         | \$115 <u>copay</u> /visit                                                                                                          | You may have to pay for services that are not <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                             |
| If you have a test                                     | <b><u>Routine diagnostic test</u></b> (e.g., x-ray, blood work)<br><b><u>Non-routine diagnostic test</u></b> (e.g., sleep study, genetic testing) | <b><u>Routine diagnostic test</u></b> : No charge<br><b><u>Non-routine diagnostic test</u></b> : \$10 - \$800 <u>copay</u> /visit | <b><u>Routine diagnostic test</u></b> : No charge<br><b><u>Non-routine diagnostic test</u></b> : Up to \$2,400 <u>copay</u> /visit | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.<br/> <u>Prior authorization</u> is required for certain Non-routine <u>diagnostic tests</u> or there may be no coverage.</p>                                                                                                                                                        |
|                                                        | Imaging (CT/PET scans, MRIs)                                                                                                                      | \$100 - \$600 <u>copay</u> /visit                                                                                                 | Up to \$1,800 <u>copay</u> /visit                                                                                                  | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.<br/> <u>Prior authorization</u> is required for certain imaging tests or there may be no coverage.</p>                                                                                                                                                                              |

| Common Medical Event                                                                                                                                                                                               | Services You May Need                                                                                                           | What You Will Pay                                |                                                                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                    |                                                                                                                                 | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> . | <b>Preventive</b>                                                                                                               | <b>Up to 90-Day Supply</b><br>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.<br><br>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 <u>out-of-pocket</u> maximum.<br><br>Your plan uses a preferred drug list which identifies the status of covered drugs.<br><br>Some drugs may require <u>preauthorization</u> . If the necessary <u>preauthorization</u> is not obtained, the drug may not be covered.<br><br>Certain items identified by your <u>preventive care</u> are covered in full and not subject to the co-pay amounts indicated. |
|                                                                                                                                                                                                                    | <b>Generic drugs</b>                                                                                                            | <b>Up to 30-Day Supply</b><br>\$10 <u>copay</u>  | Not covered                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                    |                                                                                                                                 | <b>Up to 90-Day Supply</b><br>\$25 <u>copay</u>  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                    | <b>Preferred Brand drugs</b>                                                                                                    | <b>Up to 30-Day Supply</b><br>\$50 <u>copay</u>  | Not covered                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                    |                                                                                                                                 | <b>Up to 90-Day Supply</b><br>\$125 <u>copay</u> |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Non-Preferred Brand drugs</b>                                                                                                                                                                                   | <b>Up to 30-Day Supply</b><br>\$75 <u>copay</u>                                                                                 | Not covered                                      |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                    | <b>Up to 90-Day Supply</b><br>\$175 <u>copay</u>                                                                                |                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b><u>Specialty drugs</u></b>                                                                                                                                                                                      | <b>Up to 30-Day Supply</b><br>Generic: \$50 <u>copay</u><br>Preferred: \$100 <u>copay</u><br>Non-Preferred: \$150 <u>copay</u>  | Not covered                                      | <u>Prior authorization</u> is required for certain <u>specialty drugs</u> or there may be no coverage. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                    | <b>Up to 90-Day Supply</b><br>Generic: \$125 <u>copay</u><br>Preferred: \$250 <u>copay</u><br>Non-Preferred: \$375 <u>copay</u> |                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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

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

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                     |                                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                        |
|----------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider (You will pay the least)                                          | Out-of-Network Provider (You will pay the most)                                                 |                                                                                                                                                                                                                                                                                               |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$35 <u>copay</u> /visit                                                              | \$105 <u>copay</u> /visit                                                                       | No visit limit for <u>network providers</u> and 60 visit limits for <u>out-of-network providers</u> per person per <u>plan</u> year.<br><u>Prior authorization</u> is required for certain <u>home health care</u> services or there may be no coverage.                                      |
|                                                                | <u>Rehabilitation services</u>   | \$5 - \$85 <u>copay</u> /visit                                                        | Up to \$220 <u>copay</u> /visit                                                                 | 180 visit limit for occupational therapy, physical therapy, speech therapy, cardiac rehabilitative therapy, and pulmonary rehabilitative therapy combined.<br>Visit limits are a combination of network <u>providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. |
|                                                                | <u>Habilitation services</u>     | \$5 - \$85 <u>copay</u> /visit                                                        | Up to \$220 <u>copay</u> /visit                                                                 | <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.                                                                 |
|                                                                | <u>Skilled nursing care</u>      | \$1,200 <u>copay</u> /stay                                                            | \$3,600 <u>copay</u> /stay                                                                      | 60 day limit per person per <u>plan</u> year.<br><u>Prior authorization</u> is required or there may be no coverage.                                                                                                                                                                          |
|                                                                | <u>Durable medical equipment</u> | \$0 - \$500 <u>copay</u> /equipment based on <u>DME</u> tier                          | Up to \$1,000 <u>copay</u> /equipment based on <u>DME</u> tier                                  | For <u>durable medical equipment (DME)</u> tiers and limitations, visit <a href="http://britehr.app/OakRidge">britehr.app/OakRidge</a> website.<br><u>Prior authorization</u> is required for certain <u>DME</u> or there may be no coverage.                                                 |
|                                                                | <u>Hospice services</u>          | <b>Home:</b> \$35 <u>copay</u> /visit<br><b>Inpatient:</b> \$1,600 <u>copay</u> /stay | <b>Home:</b> \$105 <u>copay</u> /visit<br><b>Inpatient:</b> \$4,800 <u>copay</u> /stay          | None                                                                                                                                                                                                                                                                                          |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                             | \$45 <u>copay</u> /visit                                                                        | For a list of providers visit <a href="http://www.vsp.com">www.vsp.com</a> 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
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Long term care
- 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)
- 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
- Chiropractic care (25 visit limit per person per plan year for network providers)
- Routine eye care (Adult)
- Routine foot care (covered for services associated with foot care for diabetes and peripheral vascular disease)
- Hearing aids

**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](http://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](http://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](http://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): 如果需要中文的帮助, 请拨打这个号码 [1-866-633-2446].

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

Pennsylvania Dutch (Deitsch): Fer Hilf griegie 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, a'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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |                 | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                        |                 | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                    |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                                                  | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                               | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                    | \$0             |
| ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                                                  | \$20 - \$75     | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                               | \$20 - \$75     | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                    | \$20 - \$75     |
| ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                                                         | \$200 - \$2,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                      | \$200 - \$2,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                           | \$200 - \$2,500 |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                     | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                  | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                       | \$0             |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |                 | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |                 | This EXAMPLE event includes services like:<br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic tests</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |                 |
| Total Example Cost                                                                                                                                                                                                                                                                                             | \$12,700        | Total Example Cost                                                                                                                                                                                                                                                          | \$5,600         | Total Example Cost                                                                                                                                                                                                                                                               | \$2,800         |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                |                 | In this example, Joe would pay:                                                                                                                                                                                                                                             |                 | In this example, Mia would pay:                                                                                                                                                                                                                                                  |                 |
| Cost sharing                                                                                                                                                                                                                                                                                                   |                 | Cost sharing                                                                                                                                                                                                                                                                |                 | Cost sharing                                                                                                                                                                                                                                                                     |                 |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                          | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                               | \$0             |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                              | \$400           | <u>Copayments</u>                                                                                                                                                                                                                                                           | \$1,300         | <u>Copayments</u>                                                                                                                                                                                                                                                                | \$900           |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                          | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                               | \$0             |
| What isn't covered                                                                                                                                                                                                                                                                                             |                 | What isn't covered                                                                                                                                                                                                                                                          |                 | What isn't covered                                                                                                                                                                                                                                                               |                 |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$60            | Limits or exclusions                                                                                                                                                                                                                                                        | \$20            | Limits or exclusions                                                                                                                                                                                                                                                             | \$0             |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$460           | The total Joe would pay is                                                                                                                                                                                                                                                  | \$1,320         | The total Mia would pay is                                                                                                                                                                                                                                                       | \$900           |

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