UCOR Formerly Grandfathered 2026 Open Enrollment Booklet

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United Cleanup Oak Ridge LLC (UCOR) HEALTH AND WELFARE BENEFIT PLAN

2026 Annual Benefits Enrollment Guide

2026 ANNUAL BENEFITS ENROLLMENT

UCOR FORMERLY GRANDFATHERED (ACTIVE AND LTD*)

Each year during our Annual Benefits Enrollment period, you have the opportunity to review your Health and Welfare benefit choices, consider your needs and choose benefits coverage for the next year. The information you and your family members need to make informed decisions about your 2026 Annual Benefits Enrollment is available in this guide and online at **https://ucor.com/benefits-center/**.

*NOTE: If you are on LTD, you are no longer considered an active employee, but you are still eligible for certain benefits as described in this guide.

2026 Annual Benefits Enrollment Dates:
October 27 – November 7, 2025

You can enroll at **MyGroupBenefits-UCOR-ORRCC.com** or call the UCOR-ORRCC Benefits Service Center at **1-800-451-8964.**

Be sure to read the enrollment instructions included with this guide. A statement of your current benefit coverages was provided to you in advance of the 2026 enrollment period.

ENROLLMENT ACTION

If you are satisfied with the medical plan you have now, you are not required to take action during the 2026 Annual Benefits Enrollment period. If you do not take action, you will be automatically enrolled in the medical plan you have today with coverage through Blue Cross Blue Shield of Tennessee (BCBST) at the 2026 premium rates. Your dental, vision and life insurance benefits will remain the same.

Enrollment action is required if you want to:

- Change your benefit coverage or coverage levels for 2026,
- Enroll in our new Group Accident or Critical Illness plans,
- **Contribute to a Flexible Spending Account (Health Care FSA or Dependent Care FSA), and/or**
- **Contribute to the Health Savings Account (HSA) offered with the HSA CDHP Medical Plan in 2026.**

The benefit election choices you make for January 1, 2026, will remain in place for the entire plan year unless you experience a qualifying life event such as a marriage, divorce, birth or adoption of a child, etc.

MAKING CHANGES DURING THE YEAR

Typically, the elections you make during Annual Enrollment will stay in effect until December 31, 2026. However, in certain circumstances, you may be able to make changes to your benefits during the year. If you experience a qualified life event, such as a marriage, divorce, birth or adoption of a child, you can make benefit changes directly related to that life event. You must initiate your qualified life event change within 31 days of the qualifying event.

To initiate a qualifying life event change, visit Empyrean at **MyGroupBenefits-UCOR-ORRCC.com** or call the UCOR-ORRCC Benefits Service Center at **1-800-451-8964** from 8:00 AM to 5:00 PM EST, Monday through Friday.

WHAT'S NEW FOR 2026?

VOLUNTARY BENEFITS

NEW! Group Accident and Critical Illness Insurance

For 2026, we're introducing Group Accident and Critical Illness Insurance through UNUM. These are voluntary health plans that you can enroll in to provide you with financial protection if you experience an accident or critical illness. These benefits provide lump-sum payments which can be used for out-of-pocket medical costs or everyday expenses. To receive coverage in 2026, you must enroll during the Annual Benefits Enrollment period. For additional information about these plans, call 1-800-635-5597 or visit **www.unum.com/employees.**

SAVINGS AND SPENDING ACCOUNTS

Dependent Care Flexible Spending Account (DCFSA)

Beginning January 1, 2026, the amount you can contribute to a Dependent Care FSA is increasing to $7,500 for single individuals (and married couples filing jointly) and $3,750 for married couples filing separately. See page 5 for more details.

TELADOC COPAY IN THE CDHPs

The copay for general medicine and mental health services from Teladoc Health is decreasing to $45 per visit in the CDHP plans. For more information, call 1-800-TELADOC or log in at **www.bcbst.com/Teladoc**.

MEDICAL PLANS

You will continue to have three medical plan options for 2026. If you do not take action during the Annual Benefits Enrollment period, you will be re-enrolled in the medical plan you have today with coverage through BCBST. **As a reminder, if you are enrolled in the HSA CDHP, you must elect to participate in the HSA.** See pages 5-6 for more details. In all three plans, your costs for medical care will be lower if you use an in-network provider. Our medical plans also include a cap on how much you pay in a given year, called the out-of-pocket maximum.

The Medical PPO Plan

The Medical PPO Plan is a traditional Preferred Provider Organization plan with higher premium rates than both the CDHP plans, but lower deductibles and set copays for most doctor visits. ***Your PPO premiums will increase for 2026.***

Health Savings Account (HSA) CDHP Medical Plan

The HSA CDHP Medical Plan is a high-deductible medical plan that includes an HSA with a contribution from UCOR. You can use these tax-free dollars for eligible medical expenses and any unused amounts are yours to keep when you retire or leave UCOR. The HSA CDHP has higher deductibles, but lower premium rates compared to the Medical PPO plan. ***Your HSA CDHP premiums will increase for 2026.***

The Consumer Directed Health Plan (CDHP)

In the CDHP, in-network deductibles will increase due to IRS requirements. This plan meets all the qualifications for an affordable medical plan under the Affordable Care Act. If you select the CDHP, you may be eligible to participate in an individual Health Savings Account or HSA, through your bank to pay for eligible medical expenses – with tax-free dollars. The CDHP has a higher deductible than the Medical PPO Plan and HSA CDHP Medical Plan and also has the lowest premium rates. In-network deductibles are increasing to $3,400 for single coverage and $6,800 for family coverage. ***Your CDHP premiums will increase for 2026.***

The 2026 premiums are on page 8. All payroll deductions will be taken weekly (i.e., over 48 weeks/4 times per month).

MEDICAL AND PRESCRIPTION DRUG COMPARISON

2026 Medical Plan Options						
Plan Design Provisions	**Medical PPO**		**HSA CDHP**		**CDHP**	
Health Savings Account (HSA) Company Contribution	N/A		$1,000 employee $2,000 employee plus one and family		N/A	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Single/Family)	$400/ $800	$1,000/ $2,000	$2,000/ $4,000	$4,000/ $8,000	$3,400/$6,800	$5,000/ $10,000
Plan Pays	80% after deductible	60% after deductible	80% after deductible	50% after deductible	50% after deductible	50% after deductible
Annual Out-of-Pocket Maximum Single/Family (Includes deductible, coinsurance and copays paid by you)	$5,100/ $10,200	$13,200/ $26,400	$4,500/ $9,000	$9,000/ $18,000	$7,000/ $14,000	$14,000/ $28,000
Physician Office Visits Participant pays per visit	$30 Primary	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Inpatient Hospital Participant pays	$100 copayment	$300 copayment + deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Outpatient Surgery Participant pays	$100 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Emergency Room Emergency Care and Non-Emergency Care	$200 copayment	$200 copayment	Deductible + 20%	Deductible + 20%	Deductible + 50%	Deductible + 50%
Lab/X-Rays Participant pays	$50 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
High-Cost Diagnostics Participant pays	Deductible + 20%	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Urgent Care Center Urgent Care and Non-Urgent Care	$75 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%

MEDICAL AND PRESCRIPTION DRUG COMPARISON (CONTINUED)

2026 Prescription Drug Coverage						
	Medical PPO		HSA CDHP		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Single/Family)	Integrated with Medical		Integrated with Medical		Integrated with Medical	
Formulary	BCBST Preferred Formulary		BCBST Preferred Formulary		BCBST Preferred Formulary	
Preventive Pharmacy List (30-day supply)						
Generic Participant pays	$10 copayment	Not covered	20%, to a max of $200	Not covered	30%, to a max of $200	Not covered
Preferred Brand Participant pays	$35 copayment	Not covered	20%, to a max of $200	Not covered	30%, to a max of $200	Not covered
Non-Preferred Brand Participant pays	$60 copayment	Not covered	30%, to a max of $200	Not covered	45%, to a max of $200	Not covered
Preventive Pharmacy List (90-day supply)						
Generic Participant pays	$30 copayment	Not covered	20%, to a max of $600	Not covered	30%, to a max of $600	Not covered
Preferred Brand Participant pays	$105 copayment	Not covered	20%, to a max of $600	Not covered	30%, to a max of $600	Not covered
Non-Preferred Brand Participant pays	$180 copayment	Not covered	30%, to a max of $600	Not covered	45%, to a max of $600	Not covered
Retail (30-day supply) or Home Delivery (90-day supply)						
Preferred Generic Participant pays	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Non-Preferred Generic Participant pays	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Preferred Brand Participant pays	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Non-Preferred Brand Participant pays	20% after deductible	20% after deductible	30% after deductible	30% after deductible	45% after deductible	45% after deductible
Self-Administered						
Preferred Specialty Participant pays	20% after deductible, to a max of $400	Not covered	20% after deductible	Not covered	30% after deductible	Not covered
Non-Preferred Specialty Participant pays	20% after deductible, to a max of $400	Not covered	30% after deductible	Not covered	45% after deductible	Not covered
Provider-Administered						
Specialty Participant pays	20% after deductible, to a max of $400	Not covered	20% after deductible	Not covered	30% after deductible	Not covered
Annual Out-of-Pocket Maximum Single/Family	Integrated with Medical		Integrated with Medical		Integrated with Medical	

The Medical PPO, HSA CDHP and CDHP Plans all use the BCBST Preferred Formulary. To view the most up-to-date prescription drug formularies from BCBST, visit **https://ucor.com/benefits-center/**.

Note: Prescription drug formularies are updated regularly by our medical plan carrier. Be sure to review the formularies regularly. Changes to the formularies during the plan year may impact your Prescription Drug Coverage.

BLUE CROSS BLUE SHIELD OF TENNESSEE (BCBST) RESOURCES

You have access to the following resources through BCBST to support your overall well-being and help you save money on healthcare expenses. These are available to you and your dependents if you're enrolled in a UCOR medical plan through BCBST.

Teladoc Health: Get treatment for everyday medical conditions like allergies, cold, fever and sore throat as well as mental health support with virtual guidance from board-certified doctors. Teladoc also covers dermatology, mental health, joint and back pain, nutrition counseling and tobacco cessation. With Teladoc, you'll be able to talk to a doctor by phone or video chat, and it's available 24/7 for non-emergencies. To get started, call 1-800-TELADOC or log in at **www.bcbst.com/Teladoc**.

Earn Rewards for Healthy Choices: You and your covered spouse can each receive up to $400 a year by making healthy decisions, getting recommended preventive screenings and participating in simple, healthy activities. BCBST will send you a $100 digital gift card when you reach 100 points — up to four times a year. Points are on a calendar year basis and do not roll over from year to year. To get started, you'll need to complete the Onlife Health Assessment first, which will earn 50 points. The Onlife Health Assessment must be completed online via the website or app; it cannot be filled in and sent to BCBST. From there, you can earn points for registering and using Teladoc, getting a flu shot, tracking walking steps, getting a preventive care exam and more! Visit **bcbst.com/yourhealth** to learn more.

Download the BCBST Mobile App!
The BCBST app makes it easier than ever to get the health information you need, when you need it. Through the app you can chat live with your BCBST care team, view your details in one place, see and share your digital ID card, find providers near you, check the drug formulary and make virtual doctor appointments.

SAVINGS AND SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) – REQUIRES ENROLLMENT FOR 2026

UCOR offers eligible employees the opportunity to enroll in both Health Care and Dependent Care Flexible Spending Accounts (FSAs). To make pre-tax contributions to a Health Care and/or Dependent Care FSA in 2026, you must re-enroll during the 2026 annual enrollment period.

- **A Health Care Flexible Spending Account (HCFSA)** allows you to be reimbursed for medical, dental and vision expenses for yourself or any IRS-eligible dependents. These contributions are deducted from your paycheck on a pre-tax basis. The full amount of your election is available for you to use immediately, even before you've contributed all the dollars. Withdrawals from the account are tax-free as long as they are used for eligible expenses. Refer to IRS Publication 502 or contact HSA Bank for a full list of qualifying expenses. Employees may contribute up to $3,300 per calendar year to an HCFSA. If you are participating in the HCFSA, you are not eligible to participate in an HSA.

  *Note: The 2026 IRS contribution limit will be finalized in late fall 2025.

- **A Dependent Care Flexible Spending Account (DCFSA)** is a pre-tax payroll deduction which allows you to be reimbursed for eligible expenses (tax-free) for the care of one or more qualifying IRS dependents that enables you (and a spouse, if applicable) to work or look for work. ***For 2026, eligible employees may contribute up to $7,500 per calendar year (household maximum) into a DCFSA***.

  HCFSA contributions may be limited for highly compensated employees (HCE). HCEs are not eligible to participate in the DCFSA. For 2026 DCFSA participation purposes, the 2026 HCE gross earnings threshold is $160,000. This rule does not apply to employees with gross earnings below the threshold.

Important! FSAs have a "USE IT OR LOSE IT" rule. You can incur expenses until the end of the plan year. You can carry over up to $660* of your unused balance in your HCFSA. You will lose any remaining funds left in your account at the end of the plan year. See the flyer in your enrollment packet to learn more about FSAs! For more details or questions, call HSA Bank at 800-357-6246 available 24/7 or visit **https://hsabank.com/HSABank/Members**.

*Subject to change for 2026, per IRS guidelines.

Health Savings Accounts (HSAs)

If you enroll in the HSA CDHP Medical Plan or CDHP, you are eligible to participate in a Health Savings Account (HSA), which is a savings account for qualified medical expenses. With an HSA, you can deposit, grow, save and pay for qualified expenses today, while saving for future qualified expenses, tax-free. This means account holders get triple tax savings.

The total amount you and UCOR can contribute to your HSA per calendar year is **$4,400 for individual** and **$8,750 for family coverage**. You can contribute up to an additional $1,000 pre-tax if you are age 55 or older or if you will turn 55 at any time during 2026

- If you select the HSA CDHP Medical Plan, UCOR will contribute **$1,000** for employee coverage and **$2,000** for employee plus one and family coverage. *Note: In order to receive the UCOR company contribution, you must enroll in the HSA CDHP and elect the HSA benefit during Annual Enrollment. You can receive the company funding without making an individual contribution, but to do so, **you must elect the benefit at $0**.* HSA Bank features a mobile app to manage your account and investment options that are aligned to your HSA and relevant to your financial objectives.

- If you select the Medical CDHP Plan, you can set up an HSA with any qualified trustee or custodian such as a bank, credit union, insurance company, or other financial institution. UCOR does not make a contribution to your account.

With HSAs, this money is yours even if you retire or leave the company. You can use the money in your HSA to pay for any eligible medical, dental and vision care expenses you have, including expenses that count toward your annual deductible and coinsurance.

See the flyer included with this guide to learn more about the HSA! For more details or questions, visit **https://ucor.com/benefits-center/**.

Update your beneficiaries! Don't forget to update beneficiaries for your HSA. Beneficiaries receive your HSA assets in the event of your death. If you are enrolled in the HSA CDHP, you can update your beneficiaries through HSA Bank.

Note: An HSA is available only to employees enrolled in an IRS-qualified high-deductible health plan, like the HSA CDHP Medical Plan or CDHP. If you are enrolled in the PPO Plan, Medicare or TriCare, you are not eligible for an HSA. For more details on HSA requirements, visit **www.irs.gov**.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

SupportLinc allows you to find in-the-moment assistance for emotional concerns and 24/7 access to licensed clinicians by phone. Through SupportLinc, you can receive short-term counseling, up to 8 session per issue, via in-person or virtual sessions, as well as coaching, text therapy, digital CBT and virtual group support to enhance emotional well-being, establish healthy habits, and build resilience. The program also includes work-life benefits, expert consultations for financial and legal matters and convenient referrals for everyday needs – all at no cost to you – while ensuring that your information remains strictly confidential. For more details, call 888-881-5462 or visit **https://www.supportlinc.com** (Group code: ucoreap1).

VISION PLAN

There will be no changes to UCOR's vision coverage and premiums for 2026. No enrollment action is needed if you want to keep the same vision benefits you have now. See page 8 for premium details. Please visit **https://ucor.com/benefits-center/** for additional information.

DENTAL PLAN

There will be no changes to UCOR's dental plans and premiums. For your 2026 coverage, no enrollment action is needed if you want to keep the same dental benefits you have now. See page 8 for premium details. Please visit **https://ucor.com/benefits-center/** for additional information.

*Please note: Cigna will no longer issue physical ID cards. Instead, you can conveniently access your digital ID card and manage your health spending through **www.myCigna.com** and the myCigna App.*

It is important to check whether your dental providers are in the Cigna network. You may use any dentist, but you will generally pay less for in-network providers. To view dental providers in the Cigna network, go to **www.myCigna.com**. To view your applicable dental plan summaries, visit **https://ucor.com/benefits-center/.**

LIFE INSURANCE

The Retiree Life, Retiree Voluntary Life and Dependent Life Insurance Plans for 2026 will continue to be offered through Securian. If you have retiree and/or retiree dependent life insurance, you may continue that coverage in 2026. You may not increase the coverage, and if you choose to drop any coverage you may not reenroll later. There are no changes to the life insurance provisions for 2026, though monthly premiums will continue to be based on retiree age bands. If you are under age 65 "and still cost sharing" life insurance and have not taken the reduced paid up option, your life insurance premiums will increase. If you have elected the reduced paid-up life benefit, you do not pay a premium. The 2026 premiums are on page 8.

At age 65, your Retiree Basic Life Insurance coverage (if applicable) was reduced, and that coverage will remain in effect for your lifetime at no cost to you.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (VOL AD&D)

The Voluntary AD&D Plan for 2026 will continue to be offered through Securian. ***There will be no changes to AD&D coverage and premiums for 2026.*** For your 2026 coverage, no enrollment action is needed if you want to keep the same AD&D benefits you have now. The coverage will be provided at the 2026 premium levels.

DISABILITY INSURANCE

Short-Term Disability (STD)

The STD plan is administered through UNUM. UCOR provides this benefit at no cost to you. There will be no changes to the STD plan for 2026.

Long-Term Disability (LTD) Plan – Basic Benefit

There will be no changes to the company-paid LTD basic benefit plan for 2026. If you are currently on LTD, you are not eligible for AD&D.

Claims and certification pertaining to STD, FMLA and/or LTD are managed by the UNUM Customer Response Center, available Monday through Friday 8:00 a.m. – 11:00 p.m. Eastern Time by calling **866-779-1054** or by logging on to the website at **www.unum.com/claims**.

NOTE: If you are currently on LTD, you are **not** eligible for Flexible Spending Accounts or Accidental Death and Dismemberment (AD&D).

2026 BENEFIT PREMIUMS

MEDICAL

Employee Weekly Premiums			
	Medical PPO	HSA CDHP	CDHP
Single	$44.50	$37.74	$32.47
Employee + Spouse	$93.46	$79.26	$68.19
Employee + 1 Child	$93.46	$79.26	$68.19
Family	$137.97	$113.23	$97.42

VISION

Employee Weekly Premiums	
Single	$0.60
Dual	$0.88
Family	$1.57

DENTAL

Employee Weekly Premiums	
Single	$3.73
Dual	$7.72
Family	$11.73

ACCIDENTAL DEATH & DISMEMBERMENT

Monthly rate per $10,000 of principal sum	
Single	$0.20
Family	$0.40

LIFE

Retiree Group Life (Rate per $1,000 per month)	
Age band	**Retiree cost share** (if applicable)
50-54	$0.064
55-59	$0.104
60-64	$0.166
Retiree Voluntary Life (Rate per $1,000 per month)	
Age band	**Retiree cost share** (if applicable)
65-69	$1.272
70-74	$2.060
75-79	$3.340
80-84	$5.412
85-89	$8.760

Voluntary Dependent Life – Spouse (Rate per $1,000 per month)	
<30 Years Old	$0.060
30-34	$0.080
35-39	$0.108
40-44	$0.168
45-49	$0.268
50-54	$0.420
55-59	$0.660
60-64	$1.068
65+	$1.720
Voluntary Dependent Life – Child (Rate per month for $10,000)	
All ages	$0.960

GROUP ACCIDENT

Employee Monthly Premiums	
Be Well Benefit: $50	
Single	$4.91
Employee + Spouse	$7.98
Employee + Children	$11.03
Family	$14.10

CRITICAL ILLNESS

Employee Monthly Premiums		
Coverage: $20,000 Be Well Benefit: $50		
Age	**Employee**	**Family**
Under 25	$4.40	$10.60
25-29	$6.00	$13.60
30-34	$8.40	$18.10
35-39	$11.20	$23.30
40-44	$15.40	$30.60
45-49	$23.80	$45.00
50-54	$38.60	$69.90
55-59	$56.00	$99.00
60-64	$82.80	$150.20
65-69	$113.80	$196.60
70+	$164.60	$282.60

INFORMATION SOURCES

You can access Empyrean's website at **MyGroupBenefits-UCOR-ORRCC.com** to make your benefit elections or contact the UCOR-ORRCC Benefits Service Center at **1-800-451-8964** from 8:00 AM to 5:00 PM EST, Monday through Friday. Prior to the 2026 Annual Benefits Enrollment period, you will receive a personalized Benefits Statement with a summary of the 2025 Health and Welfare Benefits for which you are currently enrolled. This summary will be useful in determining what benefits you may need for the coming year and whether you need to take action.

At the conclusion of the 2026 Annual Benefits Enrollment period, you will receive a personalized 2026 Benefits Confirmation Statement from Empyrean. ***Please review it carefully to ensure that it accurately reflects your benefit elections for 2026.*** Evidence of Insurability (EOI) forms may be required for new or additional life coverage, and such coverage will not be effective until your application is approved by the insurance carrier.

Benefit	Resource	Phone	Website
Benefits Enrollment	Empyrean	**(800) 451-8964**	**MyGroupBenefits-UCOR-ORRCC.com**
Medical	BCBST	**BCBST Member Services (800) 565-9140 M-F 7:00am-5:00pm CT**	**www.BCBST.com**
Rx Benefits			
Telehealth	Teladoc Health (BCBST)	**1-800-TELADOC (1-800-835-2362)**	**www.bcbst.com/Teladoc**
Employee Assistance Program (EAP)	SupportLinc	**1-888-881-LINC (5462)**	**www.supportlinc.com** Group Code: ucoreap1 (all lowercase, no spaces)
Health Savings Account and Flexible Spending Account	HSA Bank	**(800) 357-6246**	**www.hsabank.com**
Dental	Cigna	**(800) 244-6224**	**www.mycigna.com**
Vision	Vision Services Plan (VSP)	**(800) 877-7195**	**www.vsp.com**
Life	Securian	**(888) 658-0193**	**www.lifebenefits.com**
AD&D	Securian	**(888) 658-0193**	**www.lifebenefits.com**
STD/FMLA	UNUM	**(866) 779-1054**	**www.unum.com/employees www.unum.com/claims** (for claim-specific access)
LTD	UNUM	**(866) 779-1054**	**www.unum.com/employees www.unum.com/claims** (for claim-specific access)
Critical Illness and Group Accident	UNUM	**(800) 635-5597**	**www.unum.com/employees www.unum.com/claims** (for claim-specific access)
Worldwide Travel Assist Program	UNUM	**Within the US (800) 872-1414 Outside the US +(609) 986-1234**	**N/A**

Important Disclosures

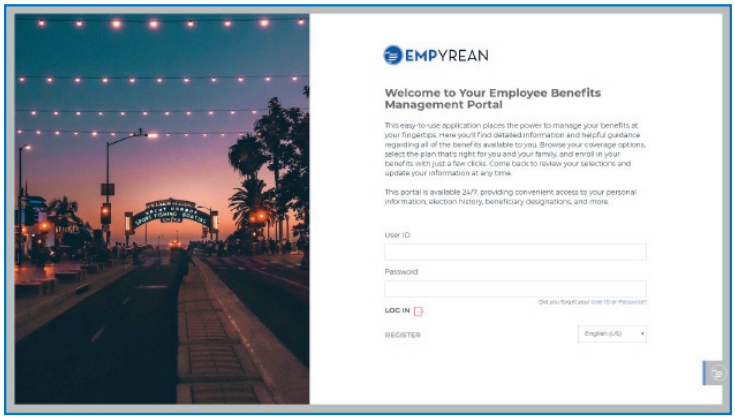
This summary information provides an overview of some of the main features of the benefit plans for eligible employees but does not reflect all of the benefits, exclusions, and limitations of the plans. For all of the plan rules, details, and coverage provisions, the terms of the plans are governed by the Plan Documents and insurance contracts. Should there be any inconsistencies between the Plan Documents and this summary information, the Plan Documents and insurance contracts will prevail. The Company reserves the right to amend or terminate any of the plans, in whole or in part, at any time.

EMPYREAN

Step by Step Enrollment Guide

This guide explains our online benefits enrollment tool. Use it to reference key steps that maximize and lock in your benefits.

Start by Registering Your User Account - *Direct Access*



1. Visit your enrollment site to create your user ID and password.
2. Click on *REGISTER.*
3. Enter your

- First, Last Name (as filed with employer),
- Date of Birth
- Social Security Number/Employee ID

—— CLICK NEXT WHEN FINISHED ——

4. Add a new User ID
(work email address, for example).
5. Create a new password with at least:

- eight characters
- one letter
- one number
- one symbol (i.e., * & + # $)

6. Set a security question and answer (at least six characters), in case you forget your password.

—— CLICK *NEXT* WHEN FINISHED ——

7. Read the terms of use agreement. To continue enrolling, click I AGREE at the bottom of the page.

NOTE
You only register once. Return and log in with your user ID and password. Our system recognizes you.

HAVE THE FOLLOWING INFORMATION HANDY

Provide eligible dependents' and beneficiaries':

- Full names
- Dates of birth
- Social security numbers

NOTE
Your Plan may require you to provide documents to verify your
dependents before they can be covered.

NOTE
Your Plan may require you to complete an Evidence of Insurability (EOI) during the enrollment process

Your registration is complete.

Please go to 'Get Ready to Enroll for Your Benefits' on page 4.

Single Sign On -
No registration required

1. Visit your enrollment site and follow the login instructions.
2. Click to access. Read the terms of use agreement. To continue enrolling, click *I AGREE* at the bottom of the page.

NOTE
If you access the system via EmpyreanGo first, you will need to complete the full registration flow, which includes
verifying yourself before creating a user ID and password.

HAVE THE FOLLOWING INFORMATION

HANDY Provide eligible dependents' and

beneficiaries':

- Full names
- Dates of birth
- Social security numbers

NOTE
Your Plan may require you to provide documents to verify
your dependents before they can be covered.

NOTE
Your Plan may require you to complete an Evidence of
Insurability (EOI) during the enrollment process

Please go to 'Get Ready to Enroll for Your Benefits' on page 4.

Get Ready to Enroll for Your Benefits.

LAUNCH YOUR ENROLLMENT

When you log in you'll see a pending event screen. (figure 1)

Click on Continue,

Begin on *My Information* step of the enrollment flow.

Follow the prompts in each step.

An indicator shows your progress per step.

GET STARTED STEP — Select if you want help choosing your healcare benefits. (figure 2)

1.1 Choose to get help with selecting your medical plan by clicking *GET OUR HELP*

NOTE

If you do not want help choosing your healthcare benefits, you can click *SELECT BENEFITS ON MY OWN* and click *Change* on the Medical benefit tile on the Select Benefits page to see options.

MY INFORMATION STEP — Personal information (figure 3)

2.1 Review your information (automatically
2.2 populated). Click the *EDIT* button to make changes.

—— Click *I'M DONE REVIEWING MY INFORMATION* when finished ——

USER TIPS

Your progress is saved when you click to continue to the next screen in the flow. You can log in later to finish your enrollment.

Click *BACK TO PREVIOUS PAGE* to review elections or make changes.

Make sure to finish your enrollment.
Elections are **NOT** recorded in the system **UNTIL** you save and accept them and get confirmation. (figure 11)

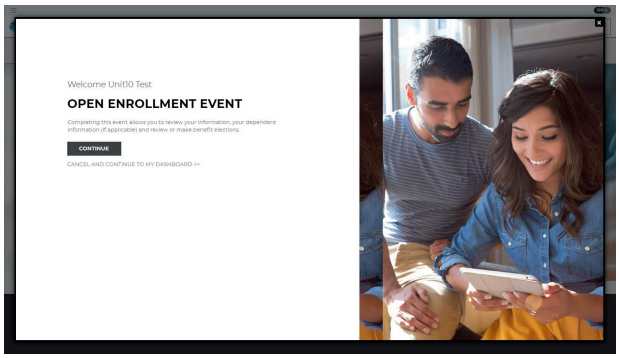


figure 1

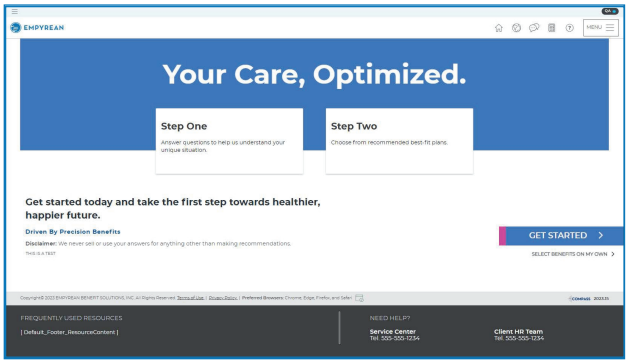


figure 2

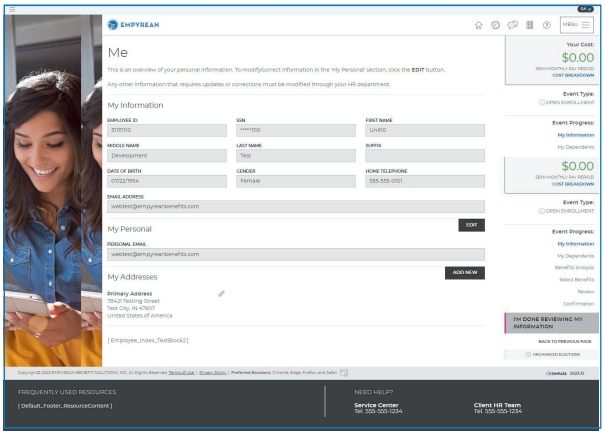


figure 3

Continue Your Enrollment

MY DEPENDENTS STEP — My family (figure 4)

3.1 To add Spouse and/or Child(ren), Click *ADD NEW*.

3.2 Click the *pencil icon* to make changes.

—— CLICK *I'M DONE WITH DEPENDENTS* WHEN FINISHED ——

NOTE

If proof of a dependent's relationship to you is required, *PENDING* appears in the *Verification Status* column.

SELECT BENEFITS STEP — Select your benefit plans

4.1 If you chose to get help, answer a 5 minute survey about your finances, health and personality. (figure 5)

4.2 Your answers will allow us to provide you with the best medical plan for you. (figure 5b)

4.3 Select the dependent(s) you wish to cover and then select the plan you want.

—— CLICK *I'M DONE WITH MY SELECTION* WHEN FINISHED ——

NOTE

A previously eligible dependent that appears in Step 3 may not appear here (for example, if they aged out). Otherwise, to add a dependent click *ADD DEPENDENTS* and revisit Step in this guide.

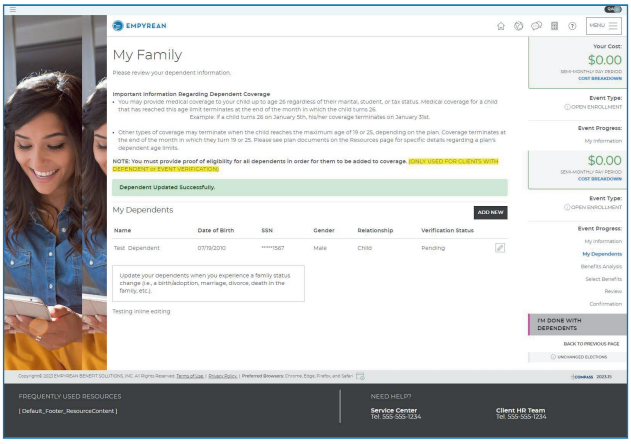


figure 4

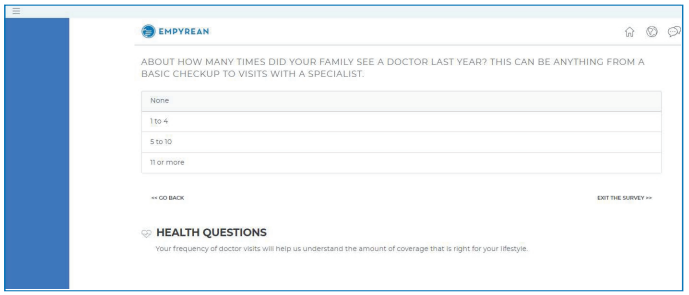


figure 5

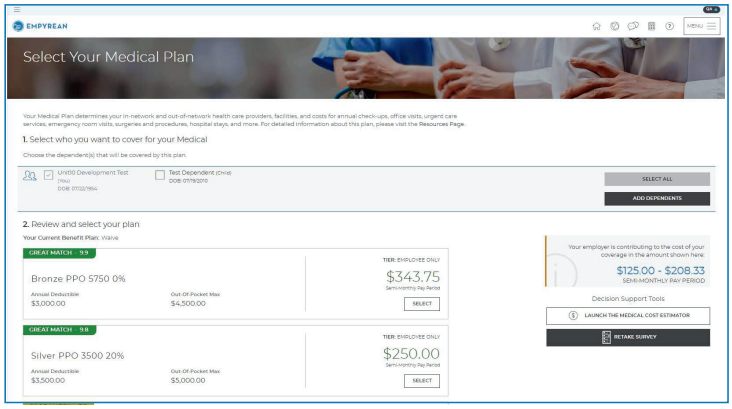


figure 5b

SELECT BENEFITS STEP — Review your selected plan (figure 6)

4.4 The plan you selected appears showing the cost per pay period for your coverage level (per dependents covered).

4.5 Review your selection. If it impacts other benefits, an alert (in the shaded box) will explain. (figure 6)

4.6 Click *VIEW COST BREAKDOWN*, if available, to see cost details.

—— CLICK *SAVE MY ELECTION* WHEN FINISHED ——

SELECT BENEFITS STEP — Continue selecting benefits (figure 7)

4.7 Click *CHANGE* on another benefit tile to select or update a plan.

4.8 Repeat until all available benefits are selected or waived.

—— CLICK *I'M DONE SELECTING BENEFITS* WHEN FINISHED ——

NOTE

Plans provided by your employer, at no cost to you, will not have a *CHANGE* button...enrollment is automatic.

NOTE

Elections screens vary per benefit (*i.e., health vs. life vs. HSA or FSA*).

NOTE

To learn more about a benefit, click *MORE DETAILS* in the lower right corner of the associated benefit tile.

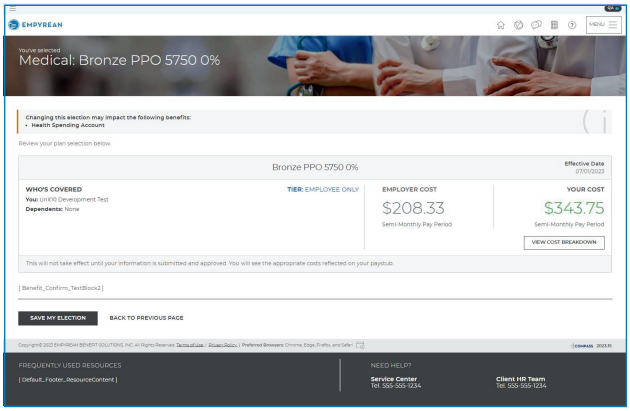


figure 6

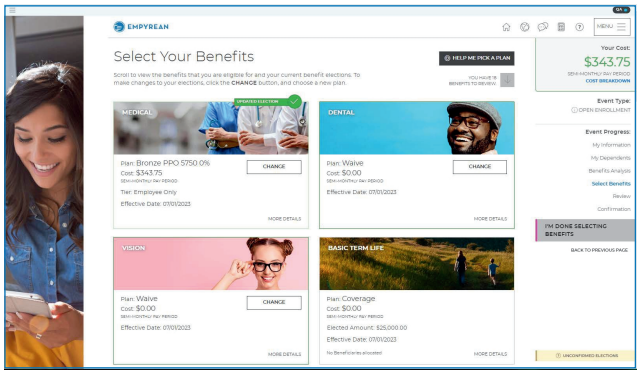


figure 7

EVENT REVIEW STEP — Review Beneficiary Allocation (figure 8)

5.1 Review, update or change designated beneficiaries.

5.2 Click *ADD NEW BENEFICIARY* to add a beneficiary.

a. Click on the *pencil icon* to edit data.
b. To delete a beneficiary, click on the *X icon*.
c. Click on *CHANGE ALLOCATION* to change beneficiary allocations for the associated benefit.

—— CLICK *I'M DONE WITH BENEFICIARIES* WHEN FINISHED ——

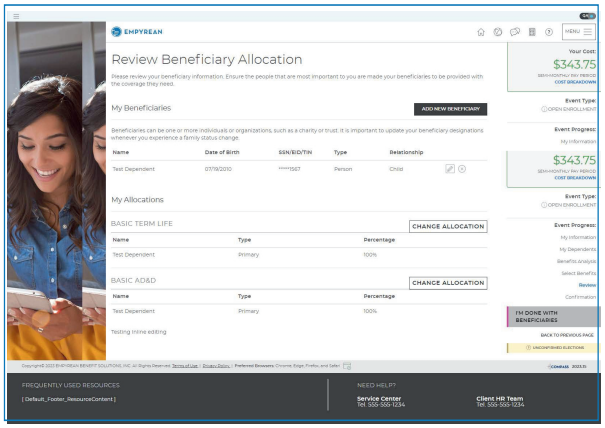


figure 8

NOTE

A red warning sign / flag and message appears if:

- A (required) beneficiary is not designated;
- You didn't allocate a portion to each beneficiary;
- Less than 100% is allocated to primary beneficiary/ies.
- Follow message prompts.

EVENT REVIEW STEP — Evidence of Insurability (EOI), Dependent Verification and/or Event Verification(figure 9)

5.3 If applicable, complete/provide EOI.

5.4 If required by your employer, verify eligibility for any dependent added for coverage by uploading required documentation.

5.5 If required by your employer, upload required documentation if the enrollment needs to be verified.

5.6 A checkmark means additional verification is not required at this time.

—— CLICK *I'M READY TO FINALIZE MY ELECTIONS* WHEN FINISHED ——

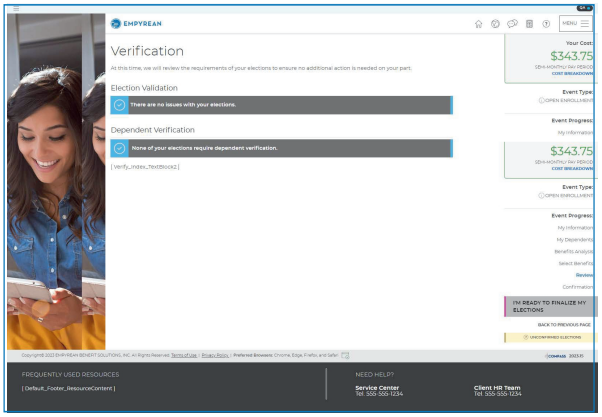


figure 9

NOTE

A warning sign and message box will indicate pending actions. Follow message prompts to fulfill them.

If you continue enrolling without completing the pending actions, certain coverage may not fully apply until they are met.

EVENT REVIEW STEP — Final Review (figure 10)

6.1 Carefully review cost summary, benefit elections, and dependent data for accuracy.

6.2 Click the *pencil icon* to make changes.

—— CLICK *SUBMIT MY ELECTIONS* WHEN FINISHED ——

One last pop-up message appears...

6.3 To continue reviewing or updating click on *DENY*
or
To confirm your enrollment click *ACCEPT.*

NOTE

When you click ***ACCEPT***, updates are recorded into the system and ready to go into effect when annual enrollment closes.

If you do not click *ACCEPT*, pending updates will not take effect

CONFIRMATION STEP — Confirmation (figure 11)

7.1 Review the final confirmation summary and use the confirmation number for future reference.

NOTE

Total costs will not match approved costs in the first four columns if:

- A part of additional life insurance is pending EOI, and/or
- Proof (as required) of a dependent's relationship to you has not been provided.

7.2 To print for your records, click *PRINT*,
or
To print later, login and click *Benefits History* from the *Home page*.

—— LOG OUT WHEN FINISHED ——

Return to manage your benefits whenever you need. See page 9 for more information.

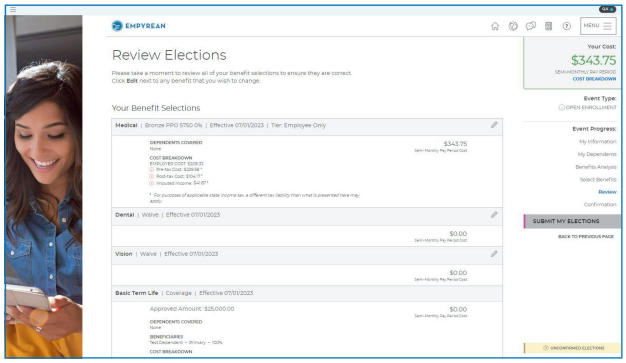


figure 10

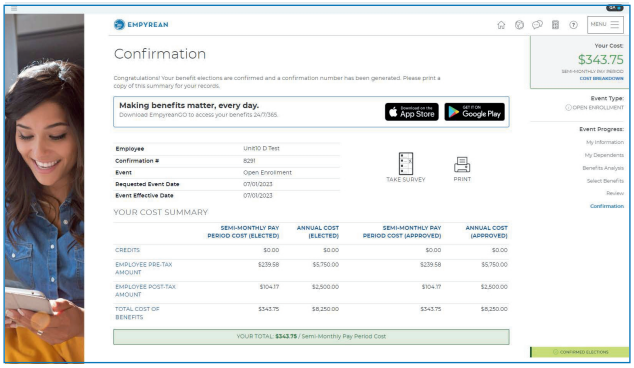


figure 11

Congratulations! You're enrolled.

MANAGE MY BENEFITS

This includes creating a qualified life event to add/drop dependents or make benefit changes.

You can do this by clicking *CHANGE YOUR CURRENT BENEFITS* from the Home page. (figure 12)

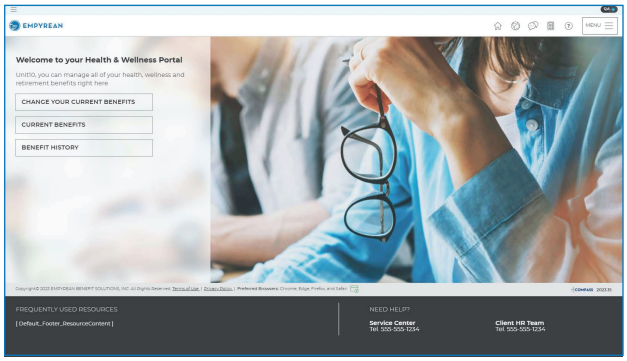


figure 12

CREATE LIFE EVENT — Select Life Event Type (figure 13)

6.1 Review the life options available and click the appropriate radio button.

—— CLICK *SAVE AND CONTINUE* WHEN FINISHED ——

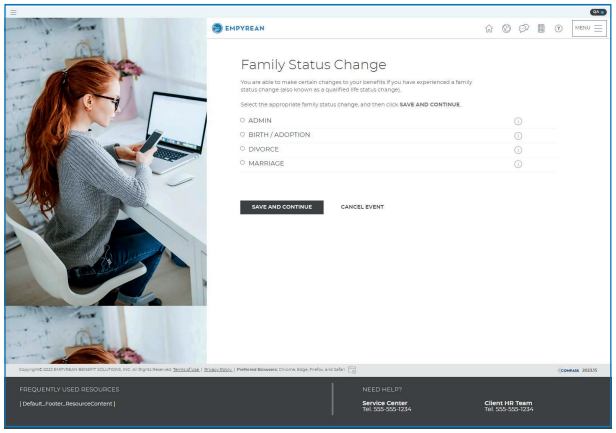


figure 13

CREATE LIFE EVENT — Select Date Life Event Occurred (figure 14)

7.1 Enter in the date the life event occured.

NOTE

Some changes may force you to use the current date as the date of the change.

See page 4 for more information on the workflow. Some pages/ steps may not apply based on the selected life event type.

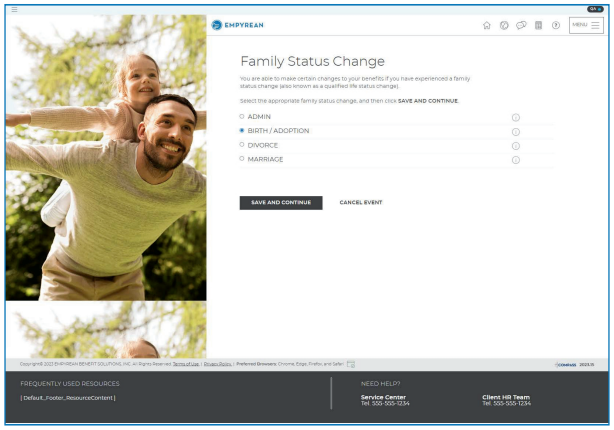


figure 14

Congratulations! You've updated your benefits.

Save Money on Your Health and Dependent Care Expenses – It's Easy!

UCOR offers **two Flexible Spending Accounts (FSAs)** to help you set aside money (pre-tax) for eligible health care and dependent care expenses – for you and your eligible IRS dependents. The money is deducted from your paycheck before taxes are taken out, just like your medical premiums (or other pre-tax deductions). You can elect to contribute up to the current IRS limits of $3,300* in the Health Care FSA and up to $7,500 in the Dependent Care FSA for the 2026 plan year.

ACTION REQUIRED! For the 2026 plan year, current employees must enroll or re-enroll for the Health Care FSA and/or Dependent Care FSA during 2026 Annual Benefits Enrollment. New hires must enroll when eligible for benefits during the new hire enrollment period to participate in FSAs for the current year, and then they must enroll during Annual Benefits Enrollment for the upcoming year.

You can use an FSA for the following eligible expenses (sample list)

Health Care FSA**

- Any costs above what your health plan pays, including deductibles and copays
- Prescriptions
- Over-the-counter drugs prescribed by your doctor
- Certain non-drug over-the-counter items, such as contact lens cleaner and bandages

Dependent Care FSA

- Licensed nursery school and childcare centers
- Private day care providers and nannies
- Licensed care for disabled dependents
- Care for an elderly parent whom you claim as a dependent on your federal income tax return
- Education expenses for a child not yet in the first grade, such as day care expenses

You cannot use the Health Care FSA to pay for dependent care expenses, and you cannot use the Dependent Care FSA to pay for health care expenses. If you expect to incur expenses like those shown above, you should consider enrolling in an FSA. Call HSA Bank at **1-800-357-6246**, visit **www.hsabank.com** or refer to IRS Publications 502 and 503, to get a full list of eligible expenses for both FSAs.

See how you save

FSAs reduce your taxable income.

Consider how Susan saves. She sets aside **$1,500** in an FSA for the year. She incurs **$1,500** worth of eligible expenses.

Susan saves

$330
22% federal income tax

Susan's tax savings mean she pays only **$1,170** for **$1,500** of expenses.

Susan pays $1,170

This hypothetical illustration is for educational purposes only. Dollar amounts or savings will vary depending on income, state and city tax rules, and other factors.

Note: Health Care FSA contributions may be limited for highly compensated employees (HCE). HCEs are not eligible to participate in the DCFSA. For 2026, the 2025 HCE gross earnings threshold is $160,000. For more information, visit **www.hsabank.com**.

*Note: The 2026 IRS contribution limit will be finalized in late fall 2025.
**If you elect a Consumer Directed Health Plan (CDHP) option for your 2026 medical coverage, you will not be eligible to elect a Health Care FSA.

READ MORE >

Ready to contribute? Key things to know!

If you elect $1,500 for the year, you'll see a deduction of $31.25 per paycheck.

Participating in an FSA takes a little planning.

You'll need to think about expenses you may have for each account when deciding how much to contribute. Remember, if you have a Health Care FSA balance left from 2025, it will carry over into 2026, up to the IRS limit.
Plus, the IRS has some rules to keep in mind. Here are some key things to know:

- **You don't need to be enrolled in a UCOR medical insurance plan** or any other type of insurance plan in order to participate in the Health Care FSA or Dependent Care FSA.
- **FSAs have a "USE IT OR LOSE IT" rule.** You can incur expenses until the end of the plan year, and you can carry over up to $660 of your unused balance in your Health Care FSA. Otherwise, will lose any remaining funds left in your account at the end of the plan year.*** Unused funds in your Dependent Care FSA ***do not*** carry over and will be forfeited at the end of the plan year.
- **Once you enroll in an FSA, you cannot make changes** to the annual contribution unless you have a qualifying mid-year life event. You must initiate your qualified life event change within 31 days of the qualifying event. If you make a mid-year change, you may not elect an amount less than what you have already spent year to date.

Paying for care

Health Care FSA

You receive an HSA Bank Debit Card

Access the **entire amount you elect to contribute** once you open the account (even though your contributions will be spread out by paycheck).
Note: In the event your debit card is not available, you may also file a claim for reimbursement.

Dependent Care FSA

You have to file a claim for reimbursement

Access the **contribution amounts as they are deducted** from your paycheck.

How FSAs work

Health Care FSA

Elect to Contribute **$1,500**	Paycheck contribution **$31.25/paycheck ($125/month)**	**$1,500** available upfront	You fill a prescription; cost is **$50**	Use your **debit card** to pay	Account balance **$1,450**

Dependent Care FSA

Elect to Contribute **$1,500**	Paycheck contribution **$31.25/paycheck ($125/month)**	**$0** available upfront	Monthly day care invoice **$100**	**File a claim**	Account balance **$25 (until the next paycheck contribution)**

***The Health Care FSA has a carryover feature for your 2025 dollars, allowing you to carry over up to $660 of unused funds from 2025 to use toward expenses incurred in 2026. This does not impact how much you can contribute in 2026.

GET ME STARTED >

To enroll in the Health and/or Dependent Care Flexible Spending Accounts, you will need to contact Empyrean at **1-800-451-8964** Monday – Friday, 8 a.m. to 5 p.m. E.T., or online at **MyGroupBenefits-UCOR-ORRCC.com** during 2026 Annual Benefits Enrollment.

Once enrolled, you can get your account information 24 hours/7 days a week via **www.hsabank.com**. You can also call HSA Bank at **1-800-357-6246**.

Consumer Directed Health Plan (CDHP) with a Health Savings Account (HSA) from UCOR

The **HSA CDHP Medical Plan** is a high-deductible plan that **includes an HSA with a contribution from UCOR**. This is money you can use for eligible medical expenses with tax-free dollars, and any unused amounts are yours to keep when you retire or leave UCOR. *Please note: In order to receive the UCOR contribution, you must elect the HSA with at least a $0.00 contribution.*

How the Plan Works

With the HSA CDHP Medical Plan you have a higher deductible* than the Medical PPO Plan, but the optional tax-free HSA and your lower monthly premiums can help you cover out-of-pocket costs. You also can carry forward unused dollars if you don't use all the money in your HSA in a particular year.

The HSA offers important advantages:

You can save. You decide how much to put into your account each year through payroll deductions. The amount you're saving on your monthly premium from switching from the PPO plan could be a great place to start. Plus, once your account reaches a certain amount, you can choose to invest using the dollars from your account.

You get UCOR contributions just for joining the plan. The contribution is based on who you enroll in the HSA CDHP – $1,000 for employee only coverage and $2,000 for employee plus one and family coverage.

You never pay taxes. You don't pay taxes on any money you and UCOR put into your HSA when it goes in or when you use it for eligible expenses.

The money (both your own contribution and UCOR's initial contribution) is available to use as it is contributed. This works differently from the Healthcare Flexible Spending Account.

It's your money. The money in your HSA is yours to pay for health care today or in the future, even if you leave the company.

Who can have an HSA?

You are eligible to contribute to an HSA if you enroll in either the HSA CDHP Medical Plan or the CDHP Medical Plan, but you will only receive the UCOR contribution to your HSA if you enroll in the HSA CDHP Medical Plan. As a reminder, to receive the UCOR company contribution, you must elect the HSA benefit during Annual Enrollment, even if you plan to contribute $0.

If you choose the CDHP Medical Plan, you can have a personal HSA that you set up on your own through a bank, for example, but you can't contribute through payroll deductions.

How Do the HSA and CDHP Work Together?

Health Savings Account
You start with contributions to the HSA

Your Contributions (optional)
+
Company Contributions

Paying for Care When Needed
You can use your HSA to pay your share of expenses

Until you meet the deductible:	You and the Company share costs:	After out-of-pocket max:
You pay 100%	**You pay 20%** **The Company pays 80%**	**Company pays 100%**

(In the network)

Carrying Funds Forward
If you have HSA dollars left

Unused dollars carry forward to 2027 and beyond

*The CDHP has the highest deductible and lowest premiums between the Medical PPO and the HSA CDHP.

READ MORE >

2026 IRS HSA Contribution Limits

The money is deducted from your paycheck before taxes are taken out, just like your medical premiums (or other pre-tax deductions). Together, contributions from you and UCOR cannot exceed the IRS-determined annual maximum for the account.

If you sign up for coverage for:	**You**	**You and covered family members**
UCOR contribution:	$1,000	$2,000
You can make additional contributions of:	$3,400	$6,750
Total contribution allowed for 2026 (IRS maximum)*:	**$4,400**	**$8,750**

*You can contribute another $1,000 if you will be age 55 or older in 2026.

How Can I Use My HSA to Cover My Deductible?

	You only	**You plus a spouse or child**	**You plus your family**
Your annual in-network deductible:	$2,000	$4,000	$4,000
UCOR's HSA contribution covers:	– $1,000	– $2,000	– $2,000
To cover your deductible, you can make HSA contributions of:	**$1,000**	**$2,000**	**$2,000**
Part of that can come from what you save in weekly premiums by selecting the HSA CDHP instead of the Medical PPO. You'll save**:	$324 *($44.50 – $37.74 = $6.76/week x 48)*	$682 *($93.46 – $79.26 = $14.20/week x 48)*	$1,188 *($137.97 – $113.23 = $24.74/week x 48)*
Part of it comes from additional contributions from you:	$676	$1,318	$812

**Rounded

WHAT YOU NEED TO KNOW TO ENROLL >

If you elect to contribute $3,400 for the year (the IRS individual max for 2026, minus the Employer contribution of $1,000), you'll see a deduction of $70.83 per paycheck ($3,400 / 48 = $70.83). During enrollment, after you elect your medical plan choice, you will need to click "I Agree" on the HSA attestation page to elect the HSA and certify you are eligible to enroll in the plan. You will also need to provide authorization for the account to be opened for you.

To enroll beginning October 27, you will need to contact Empyrean at **1-800-451-8964** Monday – Friday, 8 a.m. to 5 p.m. E.T., or online at **MyGroupBenefits-UCOR-ORRCC.com**. Once enrolled, you can get your account information 24 hours/7 days a week via **www.hsabank.com**. You can also call HSA Bank at **1-800-357-6246**.

Need to understand the difference between HSAs, HCFSAs and DCFSAs? Go to **www.hsabank.com/HSABank/Learning-Center** to learn more.

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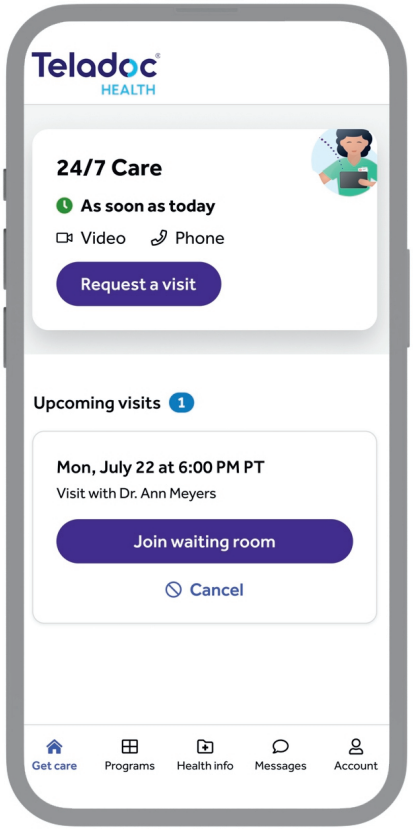
Access to quality care when you need it most

24/7 Care
Talk to a licensed healthcare provider for non-urgent conditions 24/7.
Flu • Sinus infections • Sore throats • And more

Mental Health
Talk to the therapist who's right for you by phone or video.

Dermatology
Upload images of your skin issue online and get a custom treatment plan within 24 hours.



Register or log in today

Visit TeladocHealth.com
Call 1-800-835-2362 | Download the app

Mental Health care is available for eligible members ages 18-plus.
Phone and video visits are not required or part of the dermatology visit.

TM-GM-10E-C24-02_411295158_12042019

of Tennessee

When You Need Mental Health Support

Taking care of your mental health matters. And what affects your body.

Fortunately, help for your total well-being is just a call away. We're here with extra support for depression, anxiety, eating disorders, substance use and other behavioral health challenges.

Our mental health team can connect you with:

- Counseling and treatment programs
- Community resources
- Inpatient or outpatient care

We're Here to Help

You can reach us **24/7** to get the extra care and support you need.

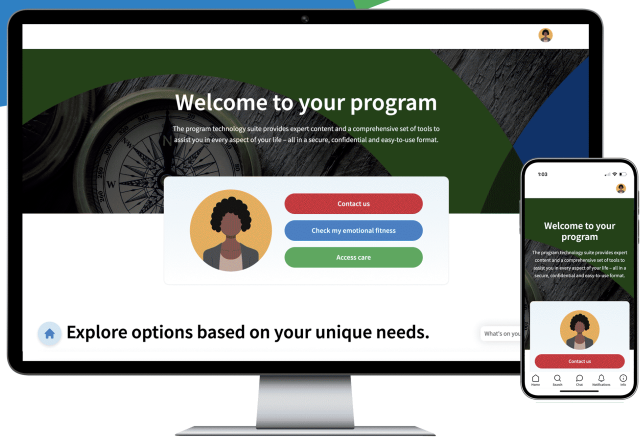
There's no cost to you.

Just give us a call at **1-800-818-8581**.

Note: This program is available for members enrolled in a BCBST medical plan. If you are not a BCBST member, you are not eligible for this service.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.

Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.

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group code: ucoreap1

Newborn's and Mother's Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call Blue Cross Blue Shield of Tennessee Member Services between 7:00am and 5:00pm CT at 1-800-565-9140.

United Cleanup Oak Ridge LLC (UCOR)
Health and Welfare Benefit Plan
2026 Annual Benefits Enrollment

Notice of Special Enrollment Rights

If you are eligible but decline to enroll in the medical benefit program under the United Cleanup Oak Ridge Health and Welfare Benefit Plan (the "Plan") for yourself or your dependents (including your spouse), under certain circumstances you may be able to enroll yourself or your dependents without waiting for the next open enrollment period. You or a dependent may be eligible for this special enrollment opportunity if you lose other medical coverage, gain a new dependent, lose coverage under certain public health programs, or become eligible for a state's premium assistance program. This notice outlines the conditions you or your dependents must meet in order to be eligible.

Loss of other coverage. If you or your dependents decline to enroll in the Plan's medical benefit program because you have other medical coverage and you/your dependents later lose that other coverage, you may be able to enroll yourself or your dependents in the medical benefit program without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. Your loss of other medical coverage qualifies for special enrollment treatment only if both of the following apply:

- You/your dependents were covered under another group health care plan or health insurance coverage at the later of the time you could have enrolled during open enrollment or, if later, at the time you were first eligible for coverage under this plan.
- You/your dependents lost the other coverage because you/they exhausted your/their right to COBRA continuation coverage, you/they were no longer eligible under that plan, or an employer's contributions for coverage terminated.

New dependents. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Public health plan eligibility and premium assistance. Will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

You will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Plan's medical benefit program.

Note that the 60-day enrollment period doesn't apply to enrollment opportunities other than a Medicaid/CHIP eligibility change.

Enrollment. Special enrollments *must* be made by completing a new enrollment form *within 31 days* of the date you/your dependents lost coverage or you acquired a new dependent, or *within 60 days* of a Medicaid/CHIP eligibility change. If you do not submit completed enrollment forms within the required 31 or 60 days of the event, you and your dependents will lose special enrollment rights for that event.

For additional questions, call the UCOR-ORRCC Benefits Service Center at 1-800-451-8964

Important Notice to Participants about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the medical benefit options sponsored by the Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan and the Oak Ridge Reservation Cleanup Contract Retiree Medical Benefit Plan (the "Plans") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. United Cleanup Oak Ridge LLC (UCOR) has determined that the prescription drug coverage under the group medical benefit options offered by the Plans for all eligible active employees is, on average, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are an active employee (or covered dependent of an active employee) who is entitled to Medicare:

- You should compare your current coverage under your Plan, including which drugs are covered, with the Medicare drug plans in your area.

- You may choose to enroll in a Medicare drug plan without impacting your prescription drug coverage under the Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan. Note, however, that Medicare drug plan will pay secondary (if at all) to the Plan. Therefore you may be paying a premium for coverage under the Medicare drug plan that you do not need.

- If you do decide to join a Medicare drug plan and drop the Plan prescription drug coverage that you may have, you and your dependents will be able to get the coverage back at a later date (such as by election during the next following annual enrollment) if you remain an active employee.

- Remember, also, that the Plan's prescription drug coverage is a part of the medical coverage under the Plan. If you drop prescription drug coverage under the Plan, you will also be dropping your medical coverage (and the medical and prescription drug coverage of your dependents, if any) under the Plan.

If you are a retiree (or covered dependent of a retiree) who is entitled to Medicare, your coverage under the Oak Ridge Reservation Cleanup Contract Retiree Medical Benefit Plan is intended to supplement your Medicare coverage. You should check to see whether your current Plan coverage already includes a Medicare drug plan. If your current Plan coverage does not include a Medicare drug plan, you can join a Medicare drug plan without impacting your current Plan coverage.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current medical coverage with the Plans and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact UCOR-ORRCC Benefits Service Center at 1-800-451-8964 for further information. NOTE: You will receive this notice each year. You may also receive it before the next period you can join a Medicare drug plan, and if the coverage through the Plans changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit http://www.medicare.gov/default.aspx
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at http://www.socialsecurity.gov/, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For more information about this notice or your prescription drug coverage, contact:

UCOR-ORRCC Benefits Service Center
1-800-451-8964

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 or 1-866-614-6005	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427`	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 1-833-522-5582 TDD: 1-888-221-1590
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

United Cleanup Oak Ridge LLC ("UCOR") understands that health information about you is personal. This Notice covers the health information practices of the United Cleanup Oak Ridge LLC Health & Welfare Benefit Plan (the "UCOR Plan"). The UCOR Plan has formed an organized health care arrangement to efficiently run the UCOR Plan and administer the benefits. Under the Health Insurance Portability and Accountability Act ("HIPAA"), the UCOR Plan is required to guard the privacy of certain personal information of members. The UCOR Plan is also considered a "hybrid entity," which means that only certain parts of the UCOR Plan have health care components covered by HIPAA and others are not. This Notice applies to the parts of the UCOR Plan that are health care components, and does not apply to certain non-covered functions including but not limited to workers compensation, Family Medical Leave Act ("FMLA"), accidental death & dismemberment (AD&D) and long-term and short-term disability programs. This Notice of Privacy Practices ("Notice") is intended to inform you, in a summary fashion, of your rights under the privacy provisions of HIPAA and the HIPAA obligations imposed on the UCOR Plan. We are required by law to abide by the terms of this Notice.

The UCOR Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all health information that is maintained including information created or received before the changes were made. All members will be notified of any changes by receiving a new notice of privacy practices.

The UCOR Plan may use and disclose certain health information called "protected health information" or "PHI" in accordance with HIPAA and as generally described in this Notice. Health information that UCOR receives about you as an employer is not PHI. Thus, your leave of absence records, Family and Medical Leave Act ("FMLA") leave information, drug testing results, workers' compensation files, disability and Occupational Safety and Health Act ("OSHA") records are not PHI and are not covered by this Notice. While this information may not be protected under HIPAA, other privacy laws and company policies will apply to ensure confidentiality.

The Benefits and Investments Committee, which serves as the Plan Administrator, and UCOR's Benefits Department who assist with the administration of the UCOR Plan have access to certain health information about you. This information is generally limited to: (1) whether you are enrolled in the UCOR Plan or are eligible; (2) the family members whom you cover under the UCOR Plan; (3) the amount which you contribute for your health care coverage, and (4) information about certain claims, claim denials, and appeals. Third parties (known as "business associates") and certain insurance companies assist the UCOR Plan in administering your health benefits. These entities keep most of the health information maintained by the UCOR Plan, such as information about your health condition, the health care services you receive, and the payments for such services. They use this information to process your benefit claims and perform other administrative functions on behalf of the UCOR Plan. The business associates are required by contract with the UCOR Plan to abide by HIPAA and only use and disclose PHI in accordance with the law.

You may request another copy of this Notice at any time by contacting the Privacy Official at (865) 576-9206.

Uses and Disclosures of PHI

The UCOR Plan may disclose your PHI to the Plan Sponsor, UCOR, for purposes related to payment and health care operations, including Plan administration. The Plan Sponsor has amended the UCOR Plan document to protect your health information so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the UCOR Plan.

The following section discusses uses and disclosures that are permitted for the UCOR Plan. The UCOR Plan may not actually engage in many of these permitted activities.

TREATMENT: The UCOR Plan may use or disclose PHI to a professional treating you. For example, a doctor may send us information about your treatment plan so the UCOR Plan can arrange additional services.

PAYMENT: The UCOR Plan may use or disclose PHI to process or pay claims for services provided to you by doctors or hospitals that are covered under the UCOR Plan. For example, we may verify your eligibility for the UCOR Plan with providers. The UCOR Plan may also use or disclose your PHI in other ways to administer benefits; for example to coordinate benefits with other health plans and to exercise subrogation rights.

HEALTH CARE OPERATIONS: The UCOR Plan may use or share certain health information for necessary health care operations. However, the UCOR Plan may not use or disclose genetic information for underwriting purposes. Examples of health care operations include but are not limited to:

- Performing quality assessment and improvement activities;
- Evaluating provider and health plan performance;
- Calculating the premium or other underwriting type activities;
- Conducting or arranging health reviews to determine health necessity, level of care or justification for services;
- Performing auditing functions;
- Resolving internal grievances, such as addressing problems or complaints regarding the UCOR Plan;
- Making benefit determinations, administering a benefit plan and providing customer service;
- Pursuing the right of recovery and reimbursement/subrogation;
- Disease Management; and
- Obtaining bids from other health plan administrators.

The UCOR Plan may also use and disclose information as permitted or required by law without a specific authorization:

To Business Associates: The UCOR Plan has hired third parties to perform certain services on behalf of the UCOR Plan. These third parties are "Business Associates" of the UCOR Plan. For example, the UCOR Plan may hire a third party administrator to review and process claims, an auditor to review such processing or an agent or broker to assist in assessing coverage options for the UCOR Plan.

Personal Representative: If you have given someone health power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. In addition, a parent of an unemancipated minor child acts as the personal representative of that minor child.

Research, Funeral Director & Organ Donation Requests: In limited circumstances, your PHI may be used or disclosed for research purposes. In addition, health information of a deceased person may be provided to a coroner, health examiner, funeral director, or organ procurement organizations for certain purposes.

As Required By Law: Your PHI may be used or disclosed as required by state or federal law. For example, PHI must be disclosed to the U.S. Department of Health and Human Services upon request for purposes of determining compliance with federal privacy laws. Health information may be disclosed: when required by workers' compensation or similar laws; to a government agency authorized to oversee the health care system or government programs or its contractors; and to public health authorities for public health purposes.

Court or Administrative Order: PHI may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances (i.e., court order, warrant, or grand jury subpoena), PHI may be disclosed to law enforcement officials. In addition, PHI may be disclosed to law enforcement officials concerning a suspect, fugitive, material witness, crime victim or missing person. PHI may be disclosed to law enforcement officials or correctional institution regarding an inmate or other person in lawful custody, in certain circumstances.

Law Enforcement: The UCOR Plan may disclose information to law enforcement officials for law enforcement purposes and to correctional institutions regarding inmates.

Avert Serious Threat to Health or Safety: The UCOR Plan may disclose information to avert a serious threat to your health or safety or that to members of the public.

Emergencies and Disaster Relief: The UCOR Plan may disclose information to organizations engaged in emergency and disaster relief.

Victim of Abuse: PHI may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. PHI may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. PHI may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military Authorities: PHI of Armed Forces personnel and veterans may be disclosed to Military authorities and the Veterans Administration under certain circumstances. PHI may also be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

Workers' Compensation: The UCOR Plan may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

Authorizations

You may provide written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time, but this

revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your health information for any reason except those described in this notice. You may not, however, cancel your authorization if it was obtained as a condition for obtaining insurance coverage and if your cancellation will interfere with the insurer's right to contest your claims for benefits under this insurance policy. The UCOR Plan may condition your enrollment or eligibility for benefits on your signing an authorization, but only if the authorization is limited to disclosing information necessary for underwriting or risk rating determinations needed for the UCOR Plan to obtain insurance coverage.

In some circumstances, we may assume that your immediate family member who is involved in your health care has your permission to receive protected health information regarding your health care, payment for, or claims regarding your health care. When we deem it in your best interest, we may thus disclose protected health information to your immediate family member for purposes directly related to his or her involvement in your health care. If you do not wish us to disclose any information to your immediate family member, you should notify the Privacy Official at (865) 576-9206 and submit a Request for Restriction on Disclosure of Protected Health Information.

The UCOR Plan will not perform any marketing of other products or sell your health information without your authorization.

Individual Rights

Access Right. You have the right to review copies of health information maintained by the UCOR Plan or one of its business associates in its designated record sets, with limited exceptions. A designated record set refers to a group of records that includes enrollment, payment, claims adjudication and care or health management record systems maintained by or for the UCOR Plan. You have the right to request either paper or electronic format. We are permitted to assess a reasonable cost-based charge for such request. If you have questions about the fee, you may use the information at the end of this Notice to contact us. We will provide you with an estimate of the cost if you want prior to fulfilling the request. In general, the UCOR Plan maintains limited health information on you and your covered dependents. Our business associates that administer or insure our group health care plan generally have more health information.

You must make your request to obtain access to your designated record set in writing. You may obtain the form to request access by using the contact information at the end of this Notice or you may send us a letter to the address located at the end of this Notice requesting access.

Additionally, under certain limited circumstances, your request to inspect or obtain a copy of your health information may be denied. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

Amendment Right. You have the right to request that the UCOR Plan amend your health information. Your request must be in writing and it must explain why the information should be amended. The UCOR Plan may deny your request if the health information you seek to amend is complete and accurate, if it was not created by the UCOR Plan or for certain other reasons. If your request is denied, the UCOR Plan will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If the UCOR Plan accepts your request to amend the information, the

UCOR Plan will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

Right of Accounting of Disclosures. You have the right to receive an accounting of the disclosures of your health information by the UCOR Plan. This accounting will list each disclosure that was made of your health information for any reason other than treatment, payment, health care operations and certain other specified activities (for example disclosed to you or pursuant to your authorization). If you request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to these additional requests. For a more detailed explanation of the fee structure, please use the information at the end of this Notice to contact our office.

Right to Request Restrictions. You have the right to request certain restrictions on the UCOR Plan's uses or disclosures of your health information. The UCOR Plan is not required to agree to all requests, but if a restriction is agreed to, the UCOR Plan will honor the agreement, except in the case of an emergency. Any request for restrictions on the use and disclosure of your health information must be in writing. The UCOR Plan is not bound unless the restriction is agreed to in writing.

You have the right to request confidential communications about your health information by alternative means or alternative locations. You must inform the UCOR Plan that you are requesting confidential communication to avoid endangerment to yourself. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. The UCOR Plan will make every effort to accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan.

Right to Notice of a Breach. If there is a breach of your unsecured protected health information that may have compromised the privacy or security of your PHI as defined by law, the UCOR Plan or its business associates will notify you in accordance with federal and state requirements.

You have the right to request and receive this Notice in paper at any time, even if you have previously received this Notice or have agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Official at the address below.

QUESTIONS AND COMPLAINTS

If you want more information concerning UCOR's privacy practices or have questions or concerns, please contact the Privacy Official at (865) 576-9206.

If you are concerned that the UCOR Plan has violated your privacy rights, you may also complain to us using the contact information above. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The UCOR Plan supports your right to protect the privacy of your health information. There will be no retaliation in any way for any exercise of your privacy rights, or if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Implementation Date: October 28, 2019

Last revised: October 1, 2019

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the UCOR-ORRCC Benefits Service Center at 1-800-451-8964.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
United Cleanup Oak Ridge LLC (UCOR)	85-2867528
5. Employer address P.O. BOX 4699, MS 7402	6. Employer phone number 865-241-1721

7. City	8. State	9. ZIP code
OAK RIDGE	TN	37831

10. Who can we contact about employee health coverage at this job?	
UCOR-ORRCC Benefits Service Center	
11. Phone number (if different from above)	12. Email address
800-451-8964	benefits@orcc.doe.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Under the UCOR Health & Welfare Benefit Plan: Eligible Employee means an Employee who is eligible to participate in the Plan pursuant to Section 3.02(a) of the Plan. Different Eligible Employees may be eligible for different Benefit options.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Under the UCOR Health & Welfare Benefit Plan: The participant's lawful spouse and Dependent Children who have not attained the age of 26 (including natural born child, step-child, legally adopted child, foster child when placed with the Participant through an accredited agency or through the courts and, subject to certain conditions, disabled children after the age of 27). Under Building Trades Employees category: Bargaining Trade Union Employees are excluded from coverage and obtain offers of insurance from their applicable union hall.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date – May 2022

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, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $400 person/$800 family Out-of-network: $1,000 person/$2,000 family	Generally, you must pay all of 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 services, Office visits, and Emergency room visits are covered before you meet your deductible (unless specified).	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,100 person/$10,200 family Out-of-network: $13,200 person/$26,400 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?	Premium, balance-billing charges, penalties, 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 http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-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.

Important Questions	Answers	Why This Matters:
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
		In-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	$30 copay/visit deductible does not apply.	40% coinsurance	Teladoc Health: $30 copay
	Specialist visit	$45 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office visit copay
	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/visit deductible does not apply.	40% coinsurance	Diagnostic testing benefits are determined by place of service, such as office or ER. Routine diagnostic if billed with an office visit, routine diagnostic is covered at 100%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Preferred Generic drugs / Non-Preferred Generic drugs	20% coinsurance	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network $10/$35/$60 copayment per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List. * **Out-of-Network Preventive drugs not covered.**
	Preferred brand drugs	20% coinsurance	40% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network $10/$35/$60 copayment per 30 day supply for generic/preferred brand/non-
	Non-preferred brand drugs	20% coinsurance	40% coinsurance	

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)	
				preferred brand drugs on Preventive Drug List. * **Out-of-Network Preventive drugs not covered.**
	Preferred Specialty drugs / Non-Preferred Specialty drugs	20% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network. Up to $400 max.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit deductible does not apply.	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	No Charge	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	Emergency room care	$200 copay/visit deductible does not apply	$200 copay/visit deductible does not apply	None
	Emergency medical transportation	$200 copay/visit deductible does not apply	$200 copay/visit deductible does not apply	None
	Urgent care	$75 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office visit copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission deductible does not apply.	$300 copay/admission/40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit deductible does not apply for office visits	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Inpatient services	$100 copay/admission deductible does not apply	$300 copay/per admission 40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	$30 copay/visit deductible	40% coinsurance	Cost sharing does not apply for preventive

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)	
		does not apply.		services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound). Initial office visit to confirm pregnancy is subject to the office visit copay.
	Childbirth/delivery facility services	$100 copay/admission deductible does not apply.	$300 copay/per admission 40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Unlimited
	Rehabilitation services	$45 copay/visit deductible does not apply	40% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	$45 copay/visit deductible does not apply	40% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	$100 copay/admission deductible does not apply	$300 copay/admission/40% coinsurance	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Hospice services	Inpatient - $100 copay/per admission Outpatient- 20% coinsurance	Inpatient - $300 copay/per admission/40% coinsurance Outpatient – 40% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Hearing aids for adults • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care for non-diabetics • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Hearing aids for children under 18 • Weight loss medications	• Infertility treatment – limited to the diagnosis & treatment of underlying medical condition • Private-duty nursing

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:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

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:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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

* For more information about limitations and exceptions, see the plan or policy document at http://www.bcbst.com/samplepolicy/2026/LG.pdf.

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 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	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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	$400
Copayments	$700
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,520**

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

The plan's overall deductible	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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	$400
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,330**

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

The plan's overall deductible	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم (الهاتف النصي: 1-800-848-0298) 1-800-565-9140

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا (TTY: 1-800-848-0298) 1-800-565-9140 تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'anáwo' bee áka'anída'awo'í dóó t'áadoole'é binahjí' bee adahodooníłgíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'anáwo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dęę' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

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, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000 person/$4,000 family Out-of-network: $4,000 person/$8,000 family	Generally, you must pay all of 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. Deductible doesn't apply to preventive care.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,500 person/$9,000 family Out-of-network: $9,000 person/$18,000 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?	Premium, balance-billing charges, penalties, 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 http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-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.

Important Questions	Answers	Why This Matters:
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
		In-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% coinsurance	50% coinsurance	Teladoc Health: $45 copay
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp or contact us at 800-565-9140	Preferred Generic drugs / Non-Preferred Generic drugs	20% coinsurance	50% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic & Preferred brand: 30-day: 20% up to $200 max; 60-day: 20% up to $400 max; 90-day: 20% up to $600 max; Non-preferred brand: 30-day: 30% up to $200 max; 60-day: 30% up to $400 max; 90-day: 30% up to $600 max
	Preferred brand drugs	20% coinsurance	50% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic & Preferred brand: 30-day: 20% up to $200 max; 60-day: 20% up to $400 max; 90-day: 20% up to $600 max; Non-preferred brand: 30-day: 30% up to $200 max; 60-day: 30%
	Non-preferred brand drugs	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at http://www.bcbst.com/samplepolicy/2026/LG.pdf.

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)	
				up to $400 max; 90-day: 30% up to $600 max
	Preferred Specialty drugs / Non-Preferred Specialty drugs	20% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and other outpatient 20% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	20% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound). Initial office visit to confirm pregnancy is subject to the office visit benefit.

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)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Unlimited
	Rehabilitation services	20% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	20% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Hospice services	20% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Hearing aids for adults • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care for non-diabetics • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Hearing aids for children under 18 • Infertility treatment	• Private-duty nursing

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:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

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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:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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 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.

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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	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,000
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$4,120**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,630**

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

The plan's overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم (الهاتف النصي: 1-800-848-0298) 1-800-565-9140

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

เอ็าใจใส่: ถ้าท่านเว้ำพาสา พาสาลาว, มีการบໍลิการ ช่วยเหຼือดำ้นพาสา และ การช่วยเหຼือ และ การบໍลิการที่เหมาะสัมให้ท่าน. กะลุนาโทหาเบิ่อยู่ฝ่ายบໍลิการสะมาชิก ที่มียู่ด้ามหัวบัด ID สะมาชิกของท่าน หื 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا (TTY: 1-800-848-0298) 1-800-565-9140 تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í dóó t'áadoole'é binahjí' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dęę' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

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, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall shared deductible?	In-network: $3,400 person/ $6,800 family Out-of-network: $5,000 person/$10,000 family	Generally, you must pay all of 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. Deductible doesn't apply to preventive care.	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 don't have to meet deductibles for specific services.
What is the embedded out-of-pocket limit for this plan?	In-network: $7,000 person/$14,000 family Out-of-network: $14,000 person/$28,000 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?	Premium, balance-billing charges, penalties, 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 http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-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
		In-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	50% coinsurance	50% coinsurance	Teladoc Health: $45 copay
	Specialist visit	50% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Preferred Generic drugs / Non-Preferred Generic drugs	30% coinsurance	30% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic and Preferred brand: 30-day: 30% up to $200 max; 60-day: 30% up to $400 max; 90-day: 30% up to $600 max; Non-preferred brand: 30-day: 45% up to $200 max; 60-day: 45% up to $400 max; 90-day: 45% up to $600 max
	Preferred brand drugs	30% coinsurance	30% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic and Preferred brand: 30-day: 30% up to $200 max; 60-day: 30% up to $400 max; 90-day: 30% up to $600 max; Non-preferred brand: 30-day: 45% up to $200 max; 60-day: 45% up to $400 max; 90-day: 45% up to $600 max
	Non-preferred brand drugs	45% coinsurance	45% coinsurance	

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* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2026/LG.pdf.

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)	
	Preferred Specialty drugs / Non-Preferred Specialty drugs	30% coinsurance/ 45% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	50% coinsurance	None
	Urgent care	50% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and other outpatient services: 50% coinsurance	50% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	50% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound). Initial office visit to confirm pregnancy is subject to the office visit benefit
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	None
If you need help	Home health care	50% coinsurance	50% coinsurance	Unlimited

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* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2026/LG.pdf.

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)	
recovering or have other special health needs	Rehabilitation services	50% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 40 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	50% coinsurance	50% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 40 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	50% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Hospice services	50% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (Children)
- Glasses (Children)
- Hearing aids for adults
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (Children)
- Routine foot care for non-diabetics
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2026/LG.pdf.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Hearing aids for children under 18 • Weight loss medications • Private duty nursing	• Infertility treatment – limited to the diagnosis and treatment of underlying medical condition

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:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

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:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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 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.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2026/LG.pdf.

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	**$3,400**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	$3,400
Copayments	$0
Coinsurance	$3,700
What isn't covered	
Limits or exclusions	$20
The total the family would pay is	**$7,120**

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

The plan's overall deductible	**$3,400**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	$3,400
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,330**

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

The plan's overall deductible	**$3,400**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم (الهاتف النصي: 1-800-848-0298) 1-800-565-9140

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

เอ็าใจใส่: ถ้าท่านเว้ำพาสา พาสาลาว, มีการบ้ลิการ ช่วยเหื่อด้านพาสา และ การช่วยเหื่อ และ การบ้ลิการที่เหมาะสั่มให้ท่าน. กะลุนาโทพาเบ็อฮ่วยฝ่ายบ้ลิการสะมาชิก ที่มีย่ด้านหู้งบัด ID สะมาชิกฮ่วยท่าน ทื่ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا (TTY: 1-800-848-0298) 1-800-565-9140 تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'anáa'awo' bee áka'anída'awo'í dóó t'áadoole'é binahjí' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'anáa'awo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dęę' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

No Surprises Act Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist

services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

SUMMARY ANNUAL REPORT
for
United Cleanup Oak Ridge Health and Welfare Benefit Plan

This is a summary of the annual report of the United Cleanup Oak Ridge Health and Welfare Benefit Plan, Employer Identification Number 85-2867528, Plan Number 501, for plan year January 1, 2024 through December 31, 2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Aetna Life Insurance Company to pay health claims, Cigna Health and Life Insurance Company and affiliates to pay dental claims, Vision Service Plan to pay vision claims and Zurich American Insurance Company to pay business travel accident claims incurred under the terms of the plan. The total amount of premium paid for the plan year ending December 31, 2024 was $23,453,388.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, upon request. The insurance information, including sales commissions paid by insurance carriers, is included in that report.

To obtain a copy of the full annual report, or any part thereof, write or call the office of the Benefits & Investments Committee at P.O. Box 4699, MS 7402, Oak Ridge, TN 37831 (865) 576-8871. The charge to cover copying costs will not exceed 25 cents per page.

You also have the legally protected right to examine the annual report at the main office of the plan (UCOR LLC, P.O. Box 4699, MS 7402, Oak Ridge, TN 37831), at the U.S. Department of Labor in Washington, D.C., or you may obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N15,13, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. ,