MCSA Active USW -1
(and LTD)
2027 Open Enrollment Booklet

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2027 Annual Benefits Enrollment Guide

2027 ANNUAL BENEFITS ENROLLMENT

MISSION CONVERSION SERVICES ALLIANCE, LLC (MCSA) USW EMPLOYEES (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 2027 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.

2027 Annual Benefits Enrollment Dates: October 26 – November 6, 2026

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 2027 enrollment period.

ENROLLMENT ACTION

If you are satisfied with the medical plan you have now, you are not required to take action during the 2027 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 2027 premium rates. Your dental, vision and life insurance benefits will remain the same.

However, enrollment action is required if you want to change your life benefit coverage or coverage levels for 2027. The benefit election choices you make for January 1, 2027 will remain in place for the entire plan year unless you experience a qualifying life event.

MAKING CHANGES DURING THE YEAR

Typically, the elections you make during Annual Enrollment will stay in effect until December 31, 2027. 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, or 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 2027?

MEDICAL PLANS

You will continue to have two medical plan options for 2027. If you do not take action during the Annual Benefits Enrollment period, you will be enrolled in the medical plan you have today with coverage through BCBST. See pages 3-4 for more details.

The Medical PPO Plan

The Medical PPO Plan is a traditional Preferred Provider Organization plan with higher premium rates than the CDHP plan, but lower deductibles and set copays for most doctor visits. ***Your monthly PPO premiums will increase for 2027.***

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. A CDHP has a higher deductible than the Medical PPO Plan, but also has lower premium rates. Like the PPO Plan, there's also a cap on how much you pay in a given year, called the out-of-pocket maximum. ***Your monthly CDHP premiums will increase for 2027.***

The 2027 monthly premiums are on page 7.

In both 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.

MEDICAL AND PRESCRIPTION DRUG COMPARISON

2027 Medical Plan Options				
Plan Design Provisions	**PPO Plan**		**CDHP**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (Single/Family)	$0/$0	$100/ $200	$3,500/ 7,000	$5,000/ $10,000
Plan Pays	100%	90% after deductible	50% after deductible	50% after deductible
Annual Out-of-Pocket Maximum Single/Family (Includes deductible, coinsurance and copays paid by you)	$600/ $1,200 Pharmacy only	$600/ $1,200	$6,550/ $13,100	$13,100/ $26,200
Physician Office Visits Participant pays per visit	No Charge	10% after deductible	50% after deductible	50% after deductible
Inpatient Hospital Participant pays	No Charge	10% after deductible	50% after deductible	50% after deductible
Outpatient Surgery Participant pays	No Charge	10% after deductible	50% after deductible	50% after deductible
Emergency Room Emergency Care and Non-Emergency Care	No Charge	No Charge	50% after deductible	50% after deductible
Lab/X-Rays Participant pays	No Charge	10% after deductible	50% after deductible	50% after deductible
High-Cost Diagnostics Participant pays	No Charge	10% after deductible	50% after deductible	50% after deductible
Urgent Care Center Urgent Care and Non-Urgent Care	No Charge	10% after deductible	50% after deductible	50% after deductible

To view the most up-to-date prescription drug formularies from BCBST, visit **https://ucor.com/benefits-center/** or **www.bcbst.com/preferredrx**.

Note: Prescription drug formularies are updated regularly by our medical plan carrier; the 2027 formulary is expected to be released in late 2026. Be sure to review the formularies regularly. Changes to the formularies during the plan year may impact your Prescription Drug Coverage.

MEDICAL AND PRESCRIPTION DRUG COMPARISON (CONTINUED)

2027 Prescription Drug Coverage				
	Medical PPO		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Single/Family)	Integrated with Medical		Integrated with Medical	
Formulary	BCBST Preferred Formulary		BCBST Preferred Formulary	
Preventive Pharmacy List (30-day supply)				
Generic Participant pays	Not covered	Not covered	30%, to a max of $200 (no deductible)	Not covered
Non-Preferred Generic Participant pays	Not covered	Not covered	30%, to a max of $200 (no deductible)	Not covered
Preferred Brand Participant pays	Not covered	Not covered	30%, to a max of $200 (no deductible)	Not covered
Non-Preferred Brand Participant pays	Not covered	Not covered	45%, to a max of $200 (no deductible)	Not covered
Preventive Pharmacy List (90-day supply)				
Generic Participant pays	Not covered	Not covered	30%, to a max of $600 (no deductible)	Not covered
Non-Preferred Generic Participant pays	Not covered	Not covered	30%, to a max of $600 (no deductible)	Not covered
Preferred Brand Participant pays	Not covered	Not covered	30%, to a max of $600 (no deductible)	Not covered
Non-Preferred Brand Participant pays	Not covered	Not covered	45%, to a max of $600 (no deductible)	Not covered
Retail (30-day supply)				
Generic Participant pays	10% no deductible	10% after deductible	30% after deductible	30% after deductible
Non-Preferred Generic Participant pays	10% no deductible	10% after deductible	30% after deductible	30% after deductible
Preferred Brand Participant pays	10% no deductible	10% after deductible	30% after deductible	30% after deductible
Non-Preferred Brand Participant pays	10% no deductible	10% after deductible	45% after deductible	45% after deductible
Home Delivery (90-day supply)				
Generic Participant pays	$5 no deductible	10% after deductible	30% after deductible	30% after deductible
Non-Preferred Generic Participant pays	$5 no deductible	10% after deductible	30% after deductible	30% after deductible
Preferred Brand Participant pays	$15 no deductible	10% after deductible	30% after deductible	30% after deductible
Non-Preferred Brand Participant pays	$15 no deductible	10% after deductible	45% after deductible	45% after deductible
Self-Administered				
Preferred Specialty Participant pays	10% no deductible	Not covered	30% after deductible	Not covered
Non-Preferred Specialty Participant pays	10% no deductible	Not covered	45% after deductible	Not covered
Provider-Administered				
Specialty Participant pays	10% no deductible	Not covered	30% after deductible	Not covered
Annual Out-of-Pocket Maximum Single/Family	Integrated with Medical		Integrated with Medical	

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 an ORRCC medical plan through BCBST.

Teladoc Health

Did you know you have access to Teladoc Health as part of your BCBST medical plan? This convenient, virtual care service connects you with licensed providers from the comfort of home – no appointment lines, no waiting rooms.

With Teladoc Health, you can 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, joint and back pain, and more. You can talk to a doctor by phone or video chat and it's available 24/7 for non-emergencies.

If you've never used Teladoc Health, here are two programs worth a closer look:

- **Nutritional Counseling:** Work one-on-one with a registered dietitian to build a personalized nutrition plan, whether your goals are weight management, chronic condition support, or simply building healthier habits. Sessions are available virtually, making it easy to fit expert guidance into your schedule.
- **Tobacco Cessation:** If you're ready to quit tobacco, Teladoc offers coaching and support designed to help you succeed, with resources tailored to your habits and goals. It's a confidential, judgment-free way to get the support you need, whenever you need it.

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 $300 a year by making healthy decisions, getting recommended preventive screenings and participating in simple, healthy activities. BCBST will send you a $75 digital gift card ─ 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 Personal Health Assessment first, which will earn 250 points. The Personal Health Assessment must be completed online via the website or app; it cannot be filled in and sent to BCBST.

Get started by logging in to your online account at **my.bcbst.com/login** or register for one if you haven't done that yet. From there, select the My Health dropdown to view your wellness rewards, do your health assessment and see what health programs are covered by your plan. Then, sign up to earn rewards at **join.personifyhealth.com/BCBST** – you can register as a first-time user. You can begin earning points immediately by connecting your activity device, getting a flu shot, tracking your steps, getting a preventive care exam and more!

Download the BCBSTN Mobile App!
The BCBSTN 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 plan details in one place, see and share your digital ID card, find providers near you, check the drug formulary and make virtual doctor appointments.



VISION PLAN

2027 vision benefits will remain unchanged, and ***monthly premiums will stay the same for 2027.*** No enrollment action is needed if you want to keep the same vision benefits you have now. The 2027 monthly premiums are on page 7. Please visit **https://ucor.com/benefits-center/** for additional information.

DENTAL PLAN

2027 dental benefits will remain unchanged, and ***monthly premiums will stay the same for 2027***. For your 2027 coverage, no enrollment action is needed if you want to keep the same dental benefits you have now. The 2027 monthly premiums are on page 7.

*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.*

Note, 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 Group Life and Voluntary Life Insurance Plans for 2027 will continue to be offered through Securian. There will be no changes to the life insurance provisions for 2027. For your 2027 coverage, no enrollment action is needed if you want to keep the same life insurance coverage you have now. The 2027 premiums are on page 7.

Group Life

There are no changes to the Group Life benefit, which is currently 2x your annual earnings. ***Group Life premiums will not change for 2027.*** If you have Group Life Insurance, but choose to drop that coverage for 2027, you will no longer be eligible for the voluntary employee life coverage. In addition, if you drop coverage and want to re-enroll at a later time, you will be required to submit Evidence of Insurability (EOI).

Voluntary Life

You can elect 1x your annual earnings. ***There will be no changes to premiums for 2027.*** If you would like to increase your coverage, you will be subject to EOI requirements.

2027 BENEFIT PREMIUMS

MEDICAL

Employee Monthly Premiums		
	Medical PPO	**CDHP**
Single	$647.30	$135.92
Employee + Spouse	$1,276.04	$421.57
Employee + 1 Child	$1,276.04	$421.57
Family	$1,796.10	$602.25

VISION

Employee Monthly Premiums	
Single	$2.80
Dual	$4.06
Family	$7.27

DENTAL

Employee Monthly Premiums	
Single	$8.19
Family	$24.56

LIFE

Employee Group Life (Rate per $1,000 per month)	
Employer Paid	$0.140
Voluntary Employee Life (Rate per $1,000 per month)	
<30 years old	$0.060
30-34	$0.080
35-39	$0.092
40-44	$0.100
45-49	$0.188
50-54	$0.300
55-59	$0.504
60-64	$0.800
65-69	$1.272
70-74	$2.060
75-79	$3.340
80-84	$5.412
85-89	$8.760

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 2027 Annual Benefits Enrollment period, you will receive a personalized Benefits Statement with a summary of the 2026 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 2027 Annual Benefits Enrollment period, you will receive a personalized 2027 Benefits Confirmation Statement from Empyrean. ***Please review it carefully to ensure that it accurately reflects your benefit elections for 2027.*** 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**
Vision	Vision Services Plan (VSP)	**(800) 877-7195**	**www.vsp.com**
Dental	Cigna	**(800) 244-6224**	**www.mycigna.com**
Life	Securian	**(888) 658-0193**	**www.lifebenefits.com**

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.

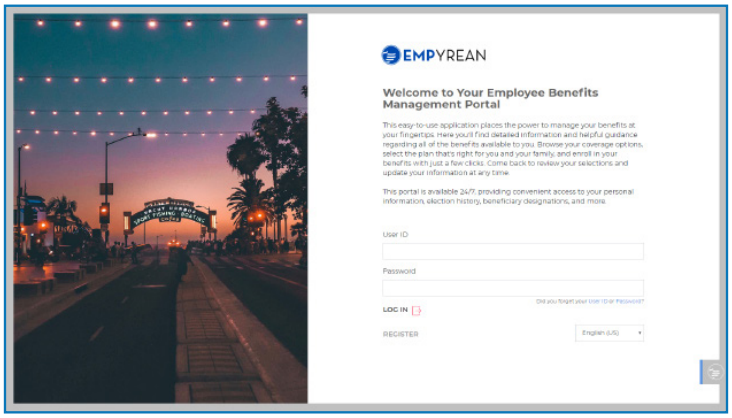


EMPYREAN

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)

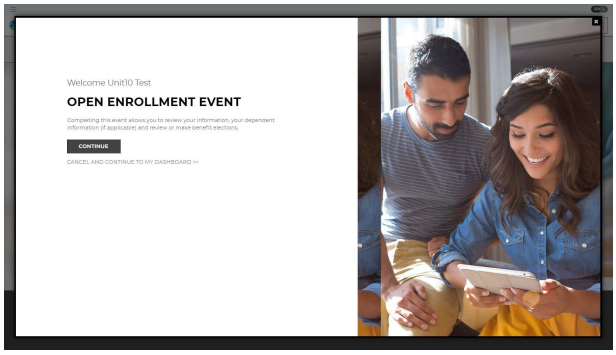


figure 1

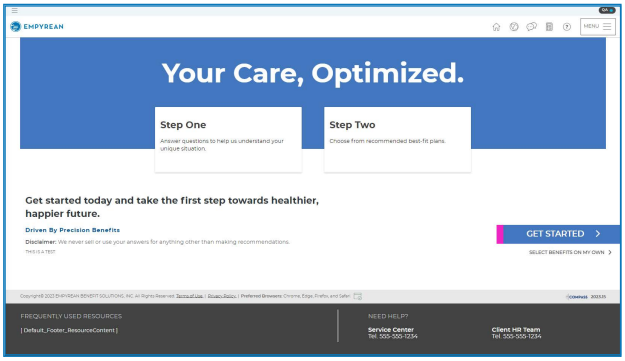


figure 2

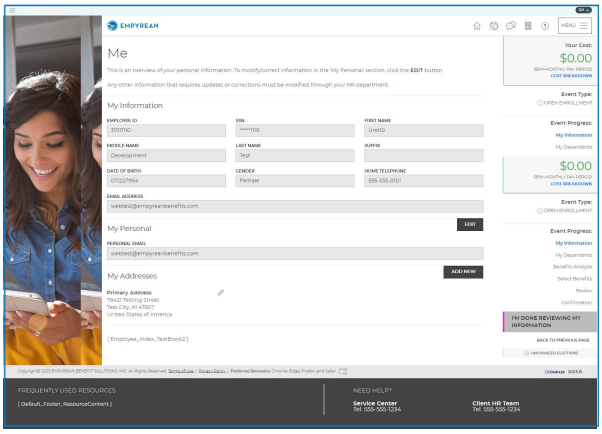


figure 3

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.

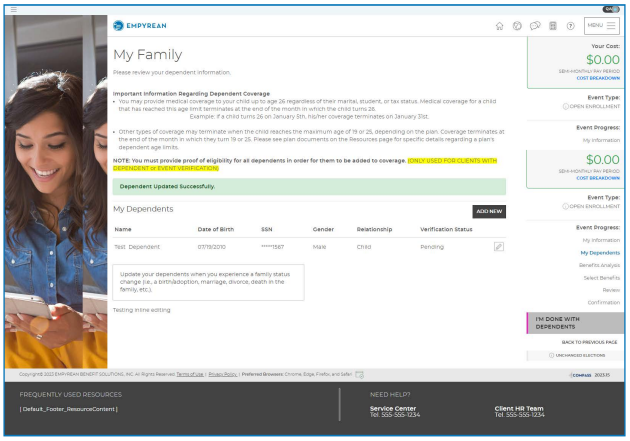


figure 4

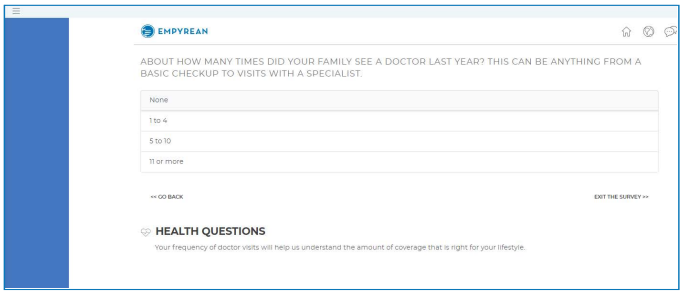


figure 5

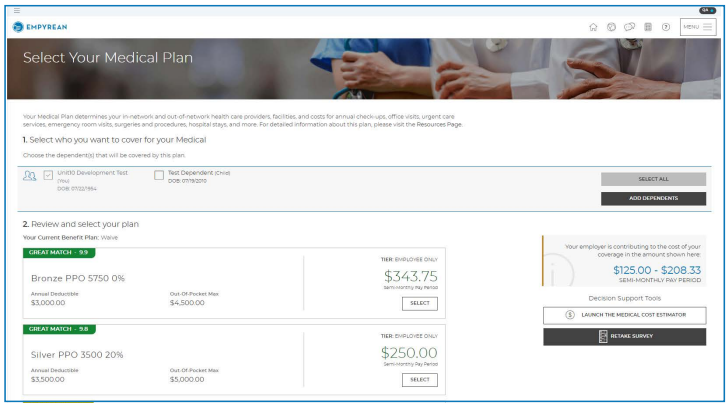


figure 5b

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.

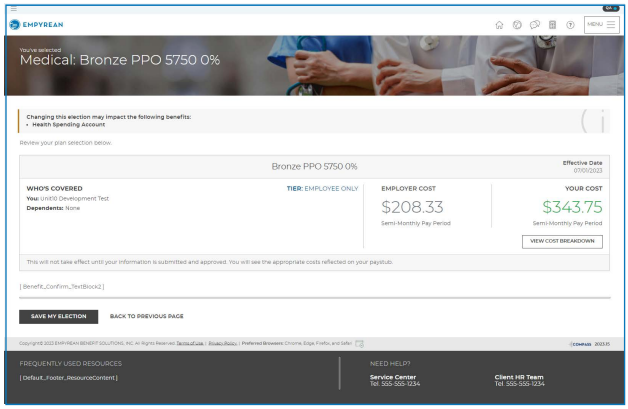


figure 6

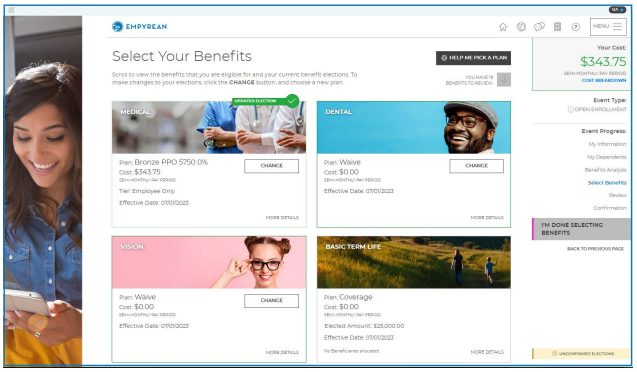


figure 7

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 ——

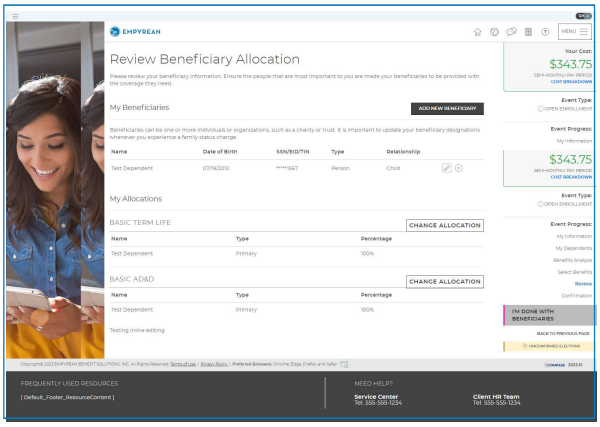


figure 8

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 ——

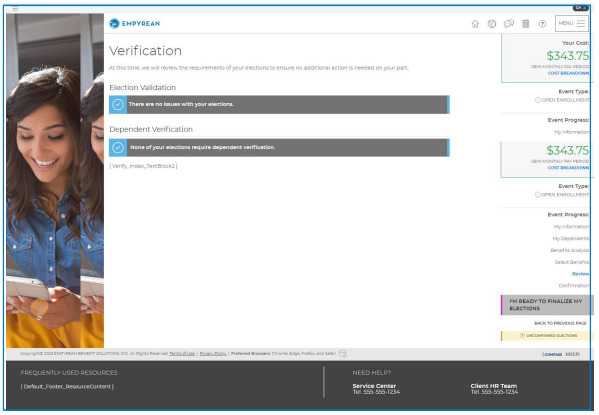


figure 9

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*.

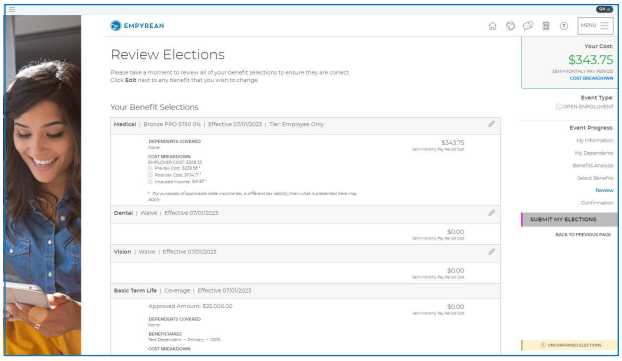


figure 10

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 ——

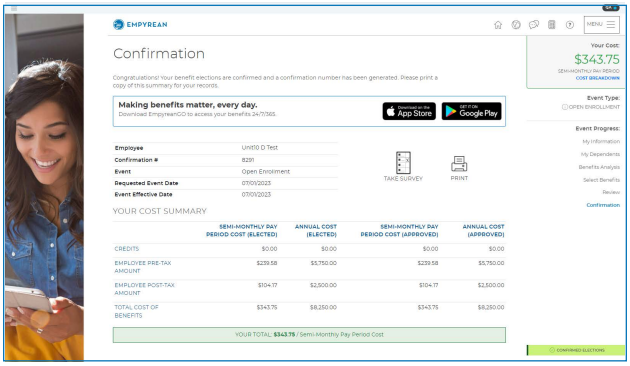


figure 11

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

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)

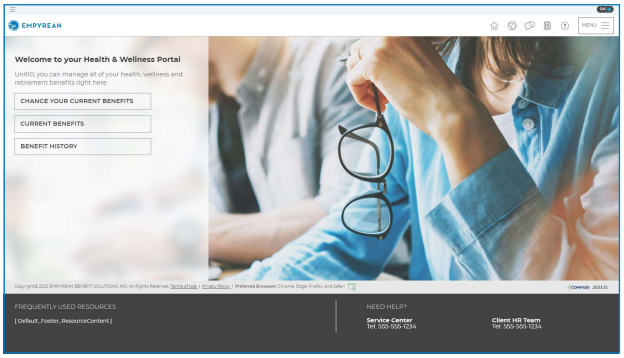


figure 12

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 ——

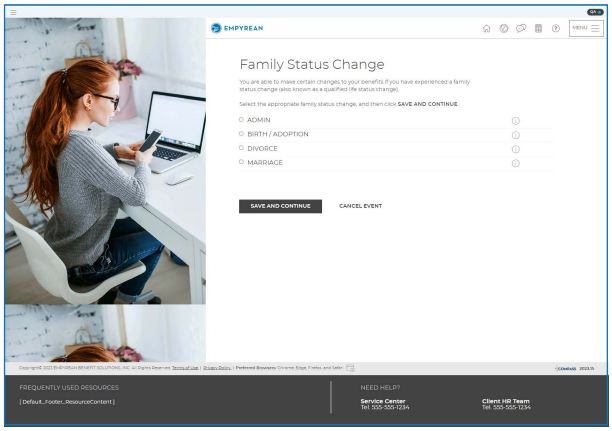


figure 13

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.

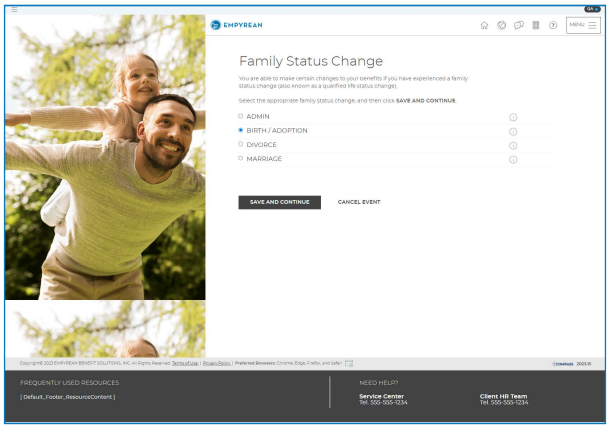


figure 14

Congratulations! You've updated your benefits.

of Tennessee

Talk to Doctors When You Need Them



Teladoc HEALTH

Use Teladoc Health® to talk to a doctor by phone or video chat. It's available 24/7 for non-emergencies, and you'll typically pay less than you would for a visit to the office or urgent care clinic.

You can use Teladoc Health for:

- General Medical: See a doctor for allergies, cold, fever, flu and more.
- Mental Health: Talk to an expert for anxiety, depression and other issues.
- Dermatology: Get treatment for skin conditions by uploading pictures.
- Nutrition Counseling: Get a nutrition plan from dietitians.
- Tobacco Cessation: Talk to a doctor about enrolling in this program.

How do I use Teladoc Health?

You'll need to register an account by answering a few quick questions. Make sure to have your Member ID card ready when you register. To get started:

- Log in to the **BCBSTN℠** app and choose **Talk to a Doctor Now**, or
- Visit **bcbst.com/Teladoc**, or
- Call **1-800-TELADOC (1-800-835-2362)**.

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.

Teladoc Health® is an independent company and does not provide BlueCross BlueShield of Tennessee products or services.
Teladoc Health is solely responsible for the products and services they provide. Teladoc Health operates subject to state and federal regulations

[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. يُرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298)

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, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. 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 નંબરે 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 1-800-565-9140 (TTY: 1-800-848-0298) 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 adahodooníłígíí 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).

25COM3021000 (2/25)

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.

Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan and Oak Ridge Reservation Cleanup Contract Retiree Medical Benefit Plan 2027 Annual Benefits Enrollment

Notice of Special Enrollment Rights

If you are eligible but decline to enroll in the medical benefit program under the Oak Ridge Reservation Cleanup Contract 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.

Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan and Oak Ridge Reservation Cleanup Contract Retiree Medical Benefit Plan

2027 Annual Benefits Enrollment

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.

Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan and Oak Ridge Reservation Cleanup Contract Retiree Medical Benefit Plan

2027 Annual Benefits Enrollment

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, 2026. 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	**ILLINOIS– 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.
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	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid Email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP Email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA

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: https://www.nj.gov/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**
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, 2026, 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 1/31/2029)

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 Oak Ridge Reservation Cleanup Contract (ORRCC) Health & Welfare Benefit Plan (the "ORRCC Plan"). The ORRCC Plan has formed an organized health care arrangement to efficiently run the ORRCC Plan and administer the benefits. Under the Health Insurance Portability and Accountability Act ("HIPAA"), the ORRCC Plan is required to guard the privacy of certain personal information of members. The ORRCC Plan is also considered a "hybrid entity," which means that only certain parts of the ORRCC Plan have health care components covered by HIPAA and others are not. This Notice applies to the parts of the ORRCC 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), life insurance 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 ORRCC Plan. We are required by law to abide by the terms of this Notice.

The ORRCC 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 ORRCC 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 ORRCC Plan have access to certain health information about you. This information is generally limited to: (1) whether you are enrolled in the ORRCC Plan or are eligible; (2) the family members whom you cover under the ORRCC 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 ORRCC Plan in administering your health benefits. These entities keep most of the health information maintained by the ORRCC 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 ORRCC Plan. The business associates are required by contract with the ORRCC 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 ORRCC 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 ORRCC 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 ORRCC Plan.

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

TREATMENT: The ORRCC 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 ORRCC Plan can arrange additional services.

PAYMENT: The ORRCC 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 ORRCC Plan. For example, we may verify your eligibility for the ORRCC Plan with providers. The ORRCC 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 ORRCC Plan may use or share certain health information for necessary health care operations. However, the ORRCC 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 ORRCC 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 ORRCC Plan may also use and disclose information as permitted or required by law without a specific authorization:

To Business Associates: The ORRCC Plan has hired third parties to perform certain services on behalf of the ORRCC Plan. These third parties are "Business Associates" of the ORRCC Plan.

For example, the ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC Plan amend your health information. Your request must be in writing and it must explain why the information should be amended. The ORRCC Plan may deny your request if the health information you seek to amend is complete and accurate, if it was not created by the ORRCC Plan or for certain other

reasons. If your request is denied, the ORRCC 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 ORRCC Plan accepts your request to amend the information, the ORRCC 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 ORRCC 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 ORRCC Plan's uses or disclosures of your health information. The ORRCC Plan is not required to agree to all requests, but if a restriction is agreed to, the ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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 ORRCC 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: May 1, 2023

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: $0 person/$0 family Out-of-network: $100 person/$200 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: $600 person/$1,200 family Out-of-network: $600 person/$1,200 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	No Charge	10% coinsurance	Teladoc Health: Covered at 100%
	Specialist visit	No Charge	10% coinsurance	None
	Preventive care/screening/ immunization	No Charge	10% 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)	No Charge	10% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	10% 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 or contact us at 800-565-9140	Preferred Generic drugs / Non-Preferred Generic drugs	10% coinsurance	10% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network; $5/$15/$15 copay. When a brand drug is chosen and a generic drug equivalent is available, you will pay the difference between the cost of the brand drug and the generic drug, plus the non-preferred brand drug copayment or coinsurance.
	Preferred brand drugs	10% coinsurance	10% coinsurance	
	Non-preferred brand drugs	10% coinsurance	10% coinsurance	
	Preferred Specialty drugs / Non-Preferred Specialty drugs	10% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	10% 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	10% 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	No Charge	No charge	None
	Emergency medical transportation	No Charge	No charge	None
	Urgent care	No Charge	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No Charge	10% 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	Office and other outpatient services: No Charge	10% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Inpatient services	No Charge	10% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	No Charge	10% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	10% coinsurance	None
	Childbirth/delivery facility services	No Charge	10% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	10% coinsurance	Unlimited
	Rehabilitation services	No Charge	10% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech and occupational therapies - limited to 100 visits combined per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/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)	
	Habilitation services	No Charge	10% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech and occupational therapies - limited to 100 visits combined per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Skilled nursing care	No Charge	10% coinsurance	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
	Durable medical equipment	No Charge	10% 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	No Charge	10% 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)
- Infertility treatment – limited to the diagnosis and treatment of underlying medical conditions
- 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
- Home childbirth delivery

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 adults
- Private-duty nursing
- Hearing aids for children under 18 limited to 1 hearing aid per ear every 3 years

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 more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

- 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.

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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/2027/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** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copay** **$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copay** **$0**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copay** **$0**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

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، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجى 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, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስጠንቀቂያ፦ 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 adahodooníłígíí diné bich'í' 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 sharedoverall deductible?	In-network: $3,500 person/ $7,000 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 embeddedout-of-pocket limit for this plan?	In-network: $6,550 person/$13,100 family Out-of-network: $13,100 person/$26,200 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	
	Non-preferred brand drugs	45% coinsurance	45% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/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

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/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)	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Unlimited
	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
- Infertility treatment – limited to the diagnosis and treatment of underlying medical conditions
- 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
- Home childbirth delivery

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/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	• 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**.
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/2027/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	**$3,500**
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	$3,500
Copayments	$0
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$20
The total the family would pay is	**$6,820**

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

The plan's overall deductible	**$3,500**
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	$3,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,430**

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

The plan's overall deductible	**$3,500**
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، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298)

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, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስጠንቀቂያ፦ 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 1-800-565-9140 (TTY: 1-800-848-0298) 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 adahodooníłígíí diné bich'í' 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).

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
OAK RIDGE RESERVATION CLEANUP CONTRACT HEALTH AND WELFARE BENEFIT PLAN

This is a summary of the annual report of the Oak Ridge Reservation Cleanup Contract Health and Welfare Benefit Plan (Employer Identification Number 85-2867528, Plan Number 510) for the plan year 1/1/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

UCOR LLC has committed itself to pay certain health flexible spending account claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with BlueCross BlueShield of Tennessee, Inc., Vision Service Plan, Securian Life Insurance Company, Cigna Health and Life Insurance Company and Affiliates and Unum Life Insurance Company of America to pay certain health, prescription drug, vision, life insurance, accidental death and dismemberment, dental and long-term disability claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were $6,106,418.

Because BlueCross BlueShield of Tennessee, Inc. is a so-called "experience-rated" contract, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2025, the premiums paid under the "experience-rated" contract were $3,475,937 and the total of all benefit claims paid under this experience-rated contract during the plan year was $2,681,528.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The item listed below is included in that report:

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at P.O. Box 4699 MS, 7402, Oak Ridge, TN 37831 and phone number, 865-241-0053.

You also have the legally protected right to examine the annual report at the main office of the plan: 701 Scarboro Road, Oak Ridge, TN 37830, and at the U.S. Department of Labor in Washington, D.C., or to 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 N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.