

**UCOR ATLC
(and LTD)
2027 Open Enrollment Booklet**

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2027 Annual Benefits Enrollment Guide

2027 ANNUAL BENEFITS ENROLLMENT

UCOR ATLC (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.

Enrollment action is required if you want to:

- **Change your life benefit coverage or coverage levels for 2027,**
- **Contribute to a Flexible Spending Account (Health Care FSA or Dependent Care FSA), and/or**
- **Contribute to the Health Savings Account (HSA) offered with the HSA CDHP Medical Plan in 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 three medical plan options for 2027. If you do not take action during the Annual Benefits Enrollment period, you will be re-enrolled in the medical plan you have today with coverage through BCBST. **As a reminder, if you are enrolled in the HSA CDHP, you must elect to participate in the HSA.** See pages 7-8 for more details. In all three plans, your costs for medical care will be lower if you use an in-network provider. Our medical plans also include a cap on how much you pay in a given year, called the out-of-pocket maximum.

The Medical PPO Plan

The Medical PPO Plan is a traditional Preferred Provider Organization plan with higher premium rates than both the CDHP plans, but lower deductibles and set copays for most doctor visits. For 2027, there will be a separate in-network prescription drug deductible, and all in-network retail and mail order costs will be subject to copays after the deductible, rather than coinsurance.

Also new for 2027 – any prescriptions filled for a 90-day supply or via mail order will be covered at 2.5 times the 30-day supply copay, down from 3 times the cost in 2026. Review the medical and prescription drug comparison charts on pages 4-5 for more details. ***Your per pay period PPO premiums will increase for 2027.***

Health Savings Account (HSA) CDHP Medical Plan

The HSA CDHP Medical Plan is a high-deductible medical plan that includes an HSA with a contribution from UCOR. You can use these tax-free dollars for eligible medical expenses and any unused amounts are yours to keep when you retire or leave UCOR. The HSA CDHP has higher deductibles, but lower premium rates compared to the Medical PPO plan. ***Your per pay period CDHP premiums will increase for 2027.***

The Consumer Directed Health Plan (CDHP)

In the CDHP, in-network deductibles will increase due to IRS requirements – to \$3,500 for single coverage and \$7,000 for family coverage. This plan meets all the qualifications for an affordable medical plan under the Affordable Care Act. If you select the CDHP, you may be eligible to participate in an individual Health Savings Account or HSA, through your bank to pay for eligible medical expenses – with tax-free dollars. The CDHP has a higher deductible than the Medical PPO Plan and HSA CDHP Medical Plan and also has the lowest premium rates. ***Your per pay period CDHP premiums will increase for 2027.***

The 2027 premiums are on pages 11-12. All payroll deductions will be taken weekly (i.e., over 48 weeks/4 times per month).

Coming Soon...

NEW VOLUNTARY BENEFITS

EARLY 2027: Special Enrollment Opportunity

UCOR will begin offering the new voluntary benefit programs listed below through a dedicated enrollment period in Q1 2027. More details – including the enrollment dates and detailed plan information – will be shared in advance of the enrollment window. Stay tuned for more information in Q4 2026!

Pet Insurance: UCOR will offer voluntary Pet Insurance through Spot Pet, giving you the option to help cover veterinary costs for accidents, illnesses, and routine wellness care for your furry family members. Plans are typically customizable, letting you choose your reimbursement level, annual deductible, and coverage cap to fit your budget and your pet's needs. Watch for more details and enrollment instructions, ahead of the special enrollment period.

Individual Disability Insurance (IDI): Eligible employees will have the opportunity to purchase Individual Disability Insurance (IDI) through UNUM to supplement your existing Long-Term Disability coverage. IDI is designed to help replace additional income lost due to a qualifying illness or injury, and unlike group LTD, the policy is portable – meaning you can keep it even if you leave UCOR. Coverage amounts and premiums are based on factors like your income and age; more details will be shared closer to the special enrollment period.

Life Insurance with Long-Term Care (LTC) Rider: UCOR will introduce a new Life Insurance with Long-Term Care (LTC) benefit through Trustmark, combining a permanent life insurance policy with the ability to access a portion of the death benefit to pay for qualifying long-term care expenses. This hybrid design means the benefit is available to you and your beneficiaries indefinitely – if you never need long-term care, your beneficiaries still receive a death benefit. And, if you leave UCOR the policy is portable; meaning you can keep it, if you want. Additional plan details, including coverage tiers and cost, will be provided before the special enrollment window opens.

MEDICAL AND PRESCRIPTION DRUG COMPARISON

2027 Medical Plan Options						
Plan Design Provisions	Medical PPO		HSA CDHP		CDHP	
Health Savings Account (HSA) Company Contribution*	N/A		\$1,000 employee \$2,000 employee plus one and family		N/A	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Single/Family)	\$400/ \$800	\$1,000/ \$2,000	\$2,000/ \$4,000	\$4,000/ \$8,000	\$3,500/ \$7,000	\$5,000/ \$10,000
Plan Pays	80% after deductible	60% after deductible	80% after deductible	50% after deductible	50% after deductible	50% after deductible
Annual Out-of-Pocket Maximum Single/Family (Includes deductible, coinsurance and copays paid by you)	\$5,100/ \$10,200	\$13,200/ \$26,400	\$4,500/ \$9,000	\$9,000/ \$18,000	\$7,000/ \$14,000	\$14,000/ \$28,000
Physician Office Visit Wellness Participant pays per visit	\$0 copayment	Deductible + 40%	\$0 copayment	Deductible + 50%	\$0 copayment	Deductible + 50%
Physician Office Visit Primary Participant pays per visit	\$30 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Physician Office Visit Specialist Participant pays per visit	\$45 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Inpatient Hospital Participant pays	\$100 copayment	\$300 copayment + deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Outpatient Surgery Participant pays	\$100 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Emergency Room Emergency Care and Non-Emergency Care	\$200 copayment	\$200 copayment	Deductible + 20%	Deductible + 20%	Deductible + 50%	Deductible + 50%
Lab/X-Rays Participant pays	\$50 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
High-Cost Diagnostics Participant pays	Deductible + 20%	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%
Urgent Care Center Urgent Care and Non-Urgent Care	\$75 copayment	Deductible + 40%	Deductible + 20%	Deductible + 50%	Deductible + 50%	Deductible + 50%

*Must be hired on or before December 1, 2027 to be eligible to receive 2027 HSA Company contribution.

MEDICAL AND PRESCRIPTION DRUG COMPARISON (CONTINUED)

2027 Prescription Drug Coverage						
	Medical PPO		HSA CDHP		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Single/Family)	<i>Separate Rx Deductible \$200/\$400</i>	Integrated with Medical	Integrated with Medical		Integrated with Medical	
Formulary	BCBST Preferred Formulary		BCBST Preferred Formulary		BCBST Preferred Formulary	
Preventive Pharmacy List (30-day supply)						
Generic	\$10 copayment	Not covered	20%, to a max of \$200	Not covered	30%, to a max of \$200	Not covered
Preferred Brand	\$35 copayment	Not covered	20%, to a max of \$200	Not covered	30%, to a max of \$200	Not covered
Non-Preferred Brand	\$60 copayment	Not covered	30%, to a max of \$200	Not covered	45%, to a max of \$200	Not covered
Preventive Pharmacy List (90-day supply)						
Generic	<i>\$25 copayment – no deductible</i>	Not covered	20%, to a max of \$600	Not covered	30%, to a max of \$600	Not covered
Preferred Brand	<i>\$87.50 copayment – no deductible</i>	Not covered	20%, to a max of \$600	Not covered	30%, to a max of \$600	Not covered
Non-Preferred Brand	<i>\$150 copayment – no deductible</i>	Not covered	30%, to a max of \$600	Not covered	45%, to a max of \$600	Not covered
Retail (30-day supply)						
Preferred Generic	\$10 copayment after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Non-Preferred Generic	\$10 copayment after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Preferred Brand	\$35 copayment after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Non-Preferred Brand	\$60 copayment after deductible	20% after deductible	30% after deductible	30% after deductible	45% after deductible	45% after deductible
Mail Order Pharmacy (90-day supply)						
Generic	<i>\$25 copay after deductible</i>	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Preferred Brand	<i>\$87.50 copay after deductible</i>	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Non-Preferred Brand	<i>\$150 copay after deductible</i>	20% after deductible	30% after deductible	30% after deductible	45% after deductible	45% after deductible
Self-Administered						
Preferred Specialty	20% after deductible, to a max of \$400	Not covered	20% after deductible	Not covered	30% after deductible	Not covered
Non-Preferred Specialty	20% after deductible, to a max of \$400	Not covered	30% after deductible	Not covered	45% after deductible	Not covered
Provider-Administered						
Specialty	20% after deductible, to a max of \$400	Not covered	20% after deductible	Not covered	30% after deductible	Not covered
Annual Out-of-Pocket Maximum	Integrated with Medical		Integrated with Medical		Integrated with Medical	

Bold and Italicized text denotes changes for 2027.

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

BLUE CROSS BLUE SHIELD OF TENNESSEE (BCBST) RESOURCES

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

Teladoc Health

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.



SAVINGS AND SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) – REQUIRES ENROLLMENT FOR 2027

UCOR offers eligible employees the opportunity to enroll in both Health Care and Dependent Care Flexible Spending Accounts (FSAs). To make pre-tax contributions to a Health Care and/or Dependent Care FSA in 2027, you must re-enroll during the 2027 annual enrollment period.

- **A Health Care Flexible Spending Account (HCFSA)** allows you to be reimbursed for medical, dental and vision expenses for yourself or any IRS-eligible dependents. These contributions are deducted from your paycheck on a pre-tax basis. The full amount of your election is available for you to use immediately, even before you've contributed all the dollars. Withdrawals from the account are tax-free as long as they are used for eligible expenses. Refer to IRS Publication 502 or contact HSA Bank for a full list of qualifying expenses. **For 2027, eligible employees may contribute up to the current IRS limit of \$3,400 per calendar year to a HCFSA.**
- **A Dependent Care Flexible Spending Account (DCFSA)** is a pre-tax payroll deduction which allows you to be reimbursed for eligible expenses (tax-free) for the care of one or more qualifying IRS dependents that enables you (and a spouse, if applicable) to work or look for work. **For 2027, eligible employees may contribute up to the current IRS limit of \$7,500 per calendar year (household maximum) to a DCFSA.**

HCFSA contributions may be limited for highly compensated employees (HCE). HCEs are not eligible to participate in the DCFSA. For 2027 DCFSA participation purposes, the 2027 HCE gross earnings threshold is \$160,000. This rule does not apply to employees with gross earnings below the threshold.

IMPORTANT! FSAs have a "USE IT OR LOSE IT" rule. You can incur expenses until the end of the plan year, and you can carry over up to \$680* of your unused balance in your Health Care FSA. Otherwise, will lose any remaining funds left in your account at the end of the plan year.** See the flyer in your enrollment packet to learn more about FSAs! For more details or questions, call HSA Bank at 1-800-357-6246 available 24/7 or visit <https://hsabank.com/HSABank/Products/HSA>.

*Subject to change for 2027, per IRS guidelines.

** Unused funds in your Dependent Care FSA do not carry over and will be forfeited at the end of the plan year.

Health Savings Accounts (HSAs) – REQUIRES ENROLLMENT FOR 2027

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

The total amount you and UCOR can contribute to your HSA per calendar year is **\$4,500 for individual** and **\$9,000 for family coverage**. You can contribute up to an additional \$1,000 pre-tax if you are age 55 or older or if you will turn 55 at any time during 2027.

- If you select the HSA CDHP Medical Plan, UCOR will contribute **\$1,000** for employee only coverage and **\$2,000** for employee plus one and family coverage. *Note: In order to receive the UCOR company contribution, you must enroll in the HSA CDHP and elect the HSA benefit during Annual Enrollment. You can receive the company funding without making an individual contribution, but to do so, **you must elect the benefit at \$0.*** HSA Bank features a mobile app to manage your account and investment options that are aligned to your HSA and relevant to your financial objectives.
- If you select the Medical CDHP Plan, you can set up an HSA with any qualified trustee or custodian such as a bank, credit union, insurance company or other financial institution. UCOR does not make a contribution to your account.

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

count toward your annual deductible and coinsurance.

See the flyer included with this guide to learn more about the HSA! For more details or questions, call HSA Bank at 1-800-357-6246 available 24/7 or visit <https://hsabank.com/HSABank/Products/HSA>.

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

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life comes with its share of challenges, and your Employee Assistance Program (EAP) through SupportLinc is here to help, at no cost to you. While many people think of EAPs primarily for counseling, SupportLinc offers a much broader range of support designed to help you better manage everyday life and unexpected challenges alike.

- **Behavioral Health Support:** Confidential counseling for stress, anxiety, depression, grief, and other life challenges, with sessions available in person, by phone, or virtually. You can receive short-term counseling, up to 8 session per issue, via in-person or virtual sessions, as well as coaching, text therapy, digital CBT and virtual group support to enhance emotional well-being, establish healthy habits, and build resilience.
- **Work-Life Resources:** Practical support and referrals for everyday needs, from managing a move to major life transitions.
- **Financial and Legal Guidance:** Free consultations with financial counselors and attorneys for help with budgeting, debt, estate planning, tax questions, and more.
- **Daycare and Senior Care Resources:** Personalized referrals to help you find and evaluate childcare and eldercare options, whether you're planning ahead or managing an urgent need.
- **Parenting Support:** Guidance and resources for managing the everyday (and not-so-everyday) challenges of raising kids, from toddlers to teens.

SupportLinc is available 24/7/365 and completely confidential, so you and your household members can get support whenever you need it. To learn more, visit www.mysupportlinc.com/.

VISION PLAN

There will be no changes to UCOR's vision coverage and premiums for 2027. No enrollment action is needed if you want to keep the same vision benefits you have now. See page 11 for premium details. Please visit <https://ucor.com/benefits-center/> for additional information.

DENTAL PLAN

There will be no changes to UCOR's dental plans and premiums. For your 2027 coverage, no enrollment action is needed if you want to keep the same dental benefits you have now. See page 11 for premium details. Please visit <https://ucor.com/benefits-center/> for additional information.

Please note: Cigna does not provide physical ID cards. Instead, you can conveniently access your digital ID card and manage your health spending through www.myCigna.com and the myCigna App.

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

LIFE INSURANCE

The 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 11.

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 and dependent life coverages. 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 *(includes Employee, Spouse and Dependent Child Voluntary Life Plans)*

You must be enrolled in Group Life to enroll in Voluntary Life coverage.

- **Voluntary Employee Life – *There will be no changes to premiums for 2027.*** If you would like to increase your coverage, you will be subject to EOI requirements.
- **Voluntary Spouse Life – *There will be no changes to premiums for 2027.*** If you would like to increase your coverage, you will be subject to EOI requirements.
- **Voluntary Child Life – *There will be no changes to premiums for 2027.*** No EOI is required for Voluntary Child Life.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (VOL AD&D)

The Voluntary AD&D Plan for 2027 will continue to be offered through Securian. ***There will be no changes to AD&D coverage and premiums for 2027.*** For your 2027 coverage, no enrollment action is needed if you want to keep the same AD&D benefits you have now. The coverage will be provided at the 2027 premium levels.

VOLUNTARY BENEFITS

Critical Illness Insurance

Provides financial protection in the event of a qualifying medical diagnosis. The benefit pays up to \$20,000 in cash payments to you for qualifying diagnoses such as stroke, heart attack, end-stage renal failure, organ transplant, bypass surgery, and brain tumors. There is no pre-existing condition exclusion, but the initial diagnosis must occur on or after the effective date of coverage.

Group Accident Insurance

Gives you peace of mind when the unexpected happens. It provides cash benefits paid directly to you for covered expenses related to an accident. It can help cover out-of-pocket expenses/copays for claims such as ER visits, urgent care visits, physical therapy visits, fractures and dislocations, X-rays and diagnostic imaging.

For **both** Critical Illness and Group Accident Insurance, earn a \$50.00 Be Well Benefit for completing one Be Well screening each year! The 2027 premiums are on page 12.

Please visit <https://ucor.com/benefits-center/> or review the UNUM flyer within this guide for additional information.

DISABILITY INSURANCE

Short-Term Disability (STD)

The STD plan is administered through UNUM. UCOR provides this benefit at no cost to you. There will be no changes to the STD plan for 2027.

Long-Term Disability (LTD) Plan – Basic Benefit

There will be no changes to the company-paid LTD basic benefit plan for 2027.

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

NOTE: If you are currently on LTD, you are not eligible for Flexible Spending Accounts, Accidental Death and Dismemberment (AD&D), or the UCOR Health Savings Account contribution.

2027 BENEFIT PREMIUMS

Weekly Premiums

MEDICAL

Employee Per Pay Period Premiums			
	Medical PPO	HSA CDHP	CDHP
Single	\$46.12	\$40.38	\$33.98
Employee + Spouse	\$96.85	\$84.81	\$79.83
Employee + 1 Child	\$96.85	\$84.81	\$79.83
Family	\$142.97	\$121.16	\$114.05

VISION

Employee Per Pay Period Premiums	
Single	\$0.60
Dual	\$0.88
Family	\$1.57

DENTAL

Employee Per Pay Period Premiums	
Single	\$1.86
Dual	\$3.86
Family	\$5.86

LIFE

Employee Group Life (Rate per \$1,000 per month)	
Employee cost share	\$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

ACCIDENTAL DEATH & DISMEMBERMENT

Monthly Rate per \$10,000 of Principal Sum	
Single	\$0.28
Family	\$0.56

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

Monthly Premiums

GROUP ACCIDENT

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

CRITICAL ILLNESS

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

Health and Welfare

“Premium Free” Pay Periods

Please note: Health & Welfare deductions will not be taken out of your paycheck for the following pay dates during the 2027 calendar year.
February 4, 2027
June 3, 2027
September 2, 2027
November 4, 2027

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 can log into your Empyrean account or call by phone to access your 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
Employee Assistance Program (EAP)	SupportLinc	1-888-881-LINC (5462)	www.mysupportlinc.com Group Code: ucoreap1 (all lowercase, no spaces)
Health Savings Account and Flexible Spending Account	HSA Bank	(800) 357-6246	www.hsabank.com
Dental	Cigna	(800) 244-6224	www.mycigna.com
Vision	Vision Services Plan (VSP)	(800) 877-7195	www.vsp.com
Life	Securian	(888) 658-0193	www.lifebenefits.com
AD&D	Securian	(888) 658-0193	www.lifebenefits.com
STD/FMLA	UNUM	(866) 779-1054	www.unum.com/employees www.unum.com/claims (for claim-specific access)
LTD	UNUM	(866) 779-1054	www.unum.com/employees www.unum.com/claims (for claim-specific access)
Critical Illness and Group Accident	UNUM	(800) 635-5597	www.unum.com/employees www.unum.com/claims (for claim-specific access)
Worldwide Travel Assist Program	UNUM	Within the US (800) 872-1414 Outside the US +(609) 986-1234	N/A

Important Disclosures

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

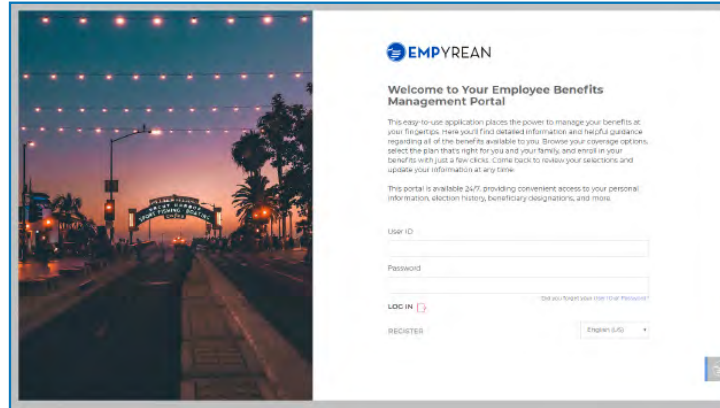


Step by Step Enrollment Guide

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 healthcare 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 populated).
- 2.2 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)

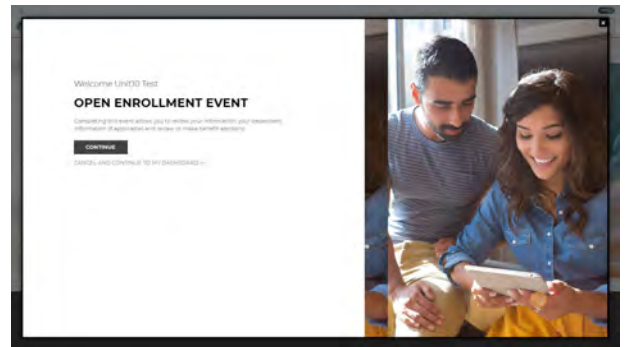


figure 1

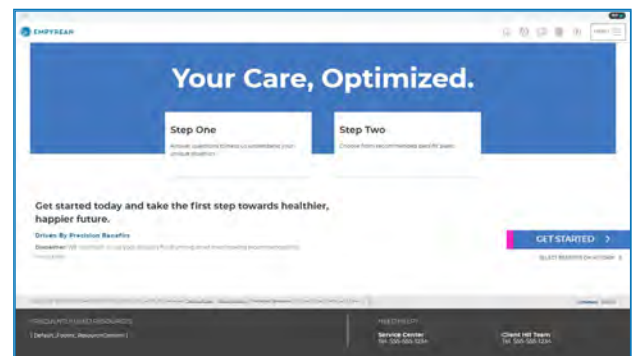


figure 2

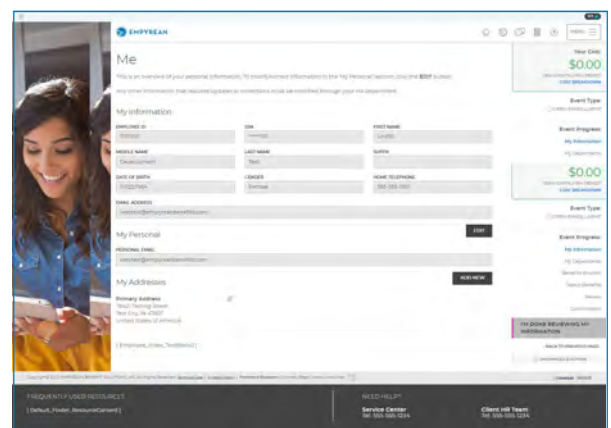


figure 3

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.

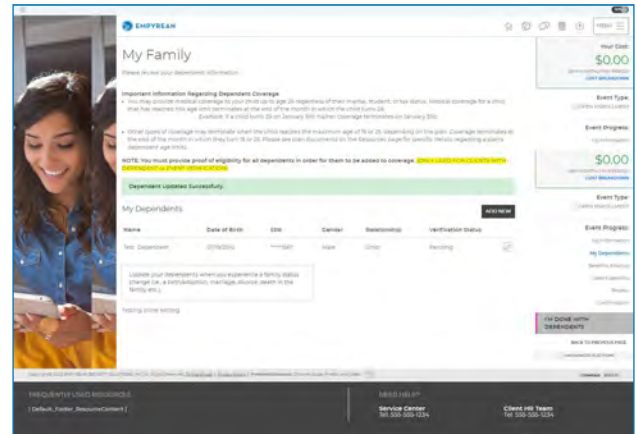


figure 4

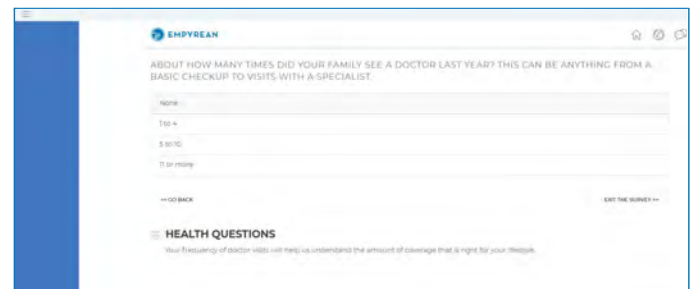


figure 5

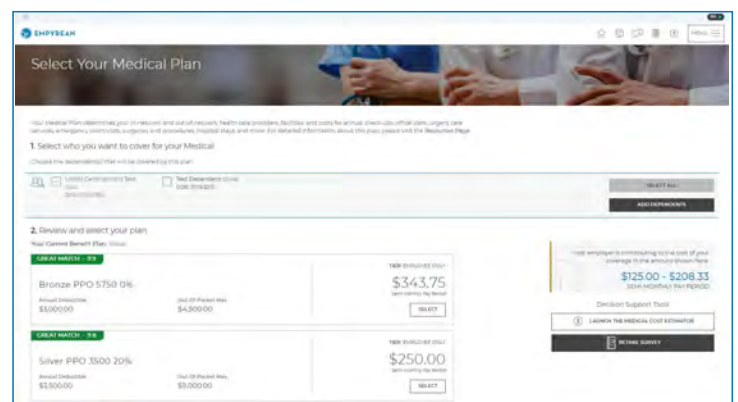


figure 5b

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.

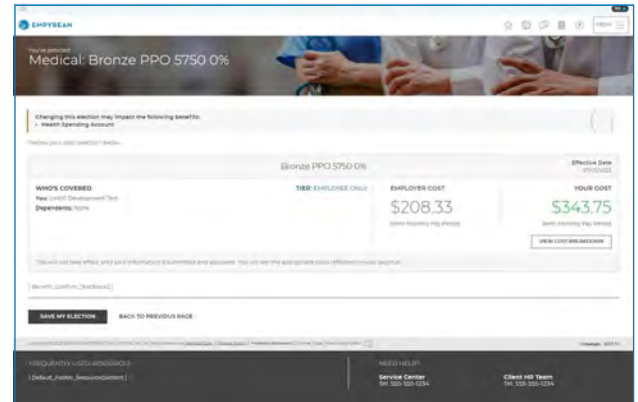


figure 6

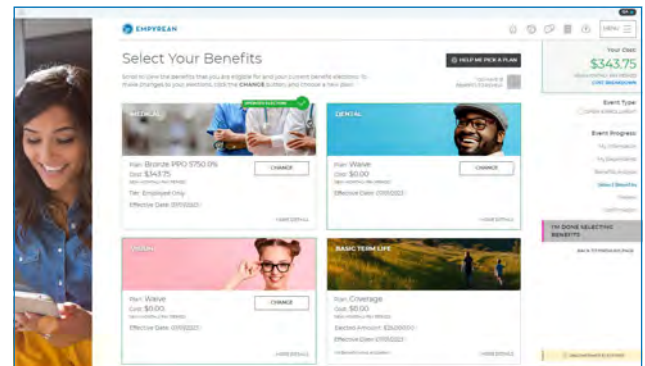


figure 7

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.

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

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

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 —

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.

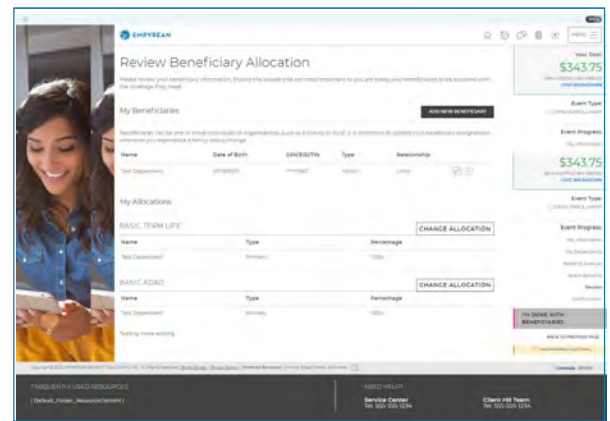


figure 8

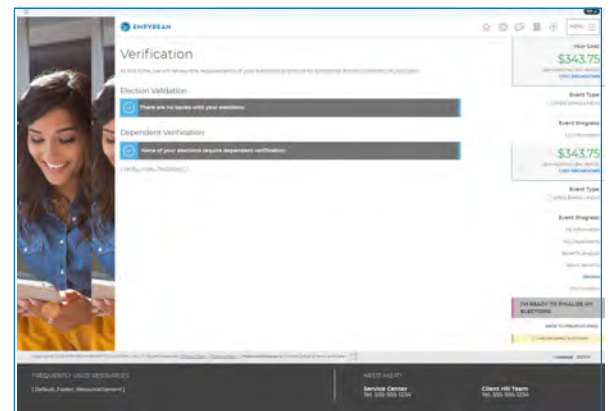


figure 9

EVENT REVIEW STEP — Final Review (figure 10)

- 6.1 Carefully review cost summary, benefit elections, and dependent data for accuracy.
- 6.2 Click the [pencil icon](#) to make changes.

— CLICK [SUBMIT MY ELECTIONS](#) WHEN FINISHED —

One last pop-up message appears...

- 6.3 To continue reviewing or updating click on [DENY](#) or
To confirm your enrollment click [ACCEPT](#).

NOTE

When you click [ACCEPT](#), updates are recorded into the system and ready to go into effect when annual enrollment closes.

If you do not click [ACCEPT](#), pending updates will not take effect

CONFIRMATION STEP — Confirmation (figure 11)

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

NOTE

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

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

- 7.2 To print for your records, click [PRINT](#),
or
To print later, login and click [Benefits History](#) from the [Home page](#).

— LOG OUT WHEN FINISHED —

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

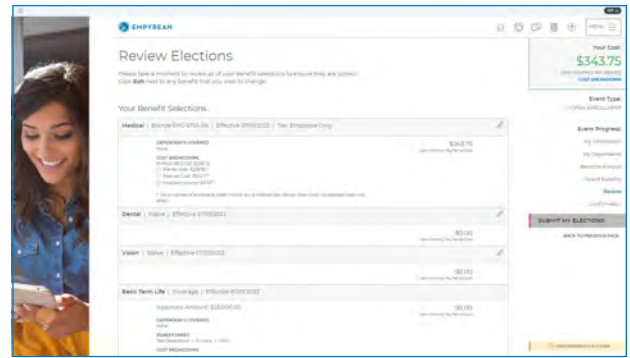


figure 10

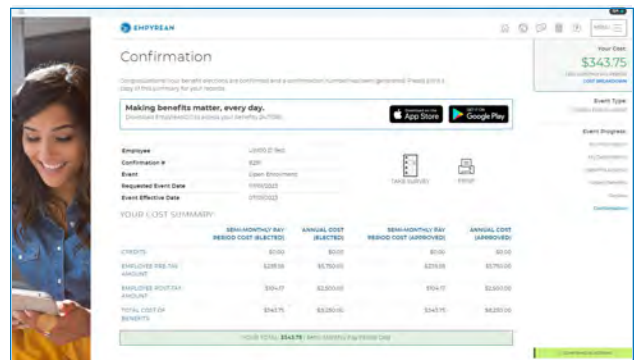


figure 11

Congratulations! You're enrolled.

MANAGE MY BENEFITS

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

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

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 —

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

7.1 Enter in the date the life event occurred.

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.

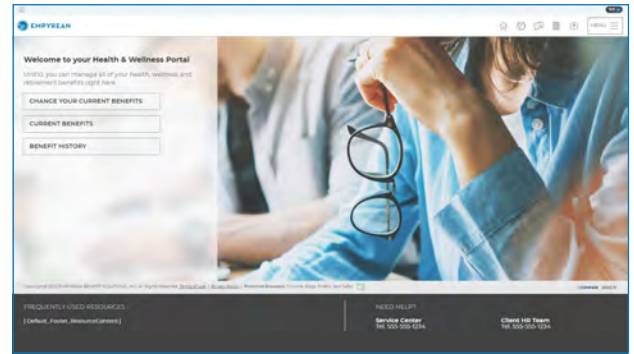


figure 12

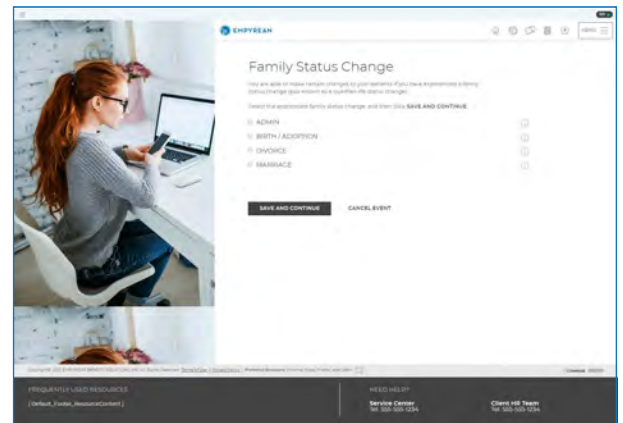


figure 13

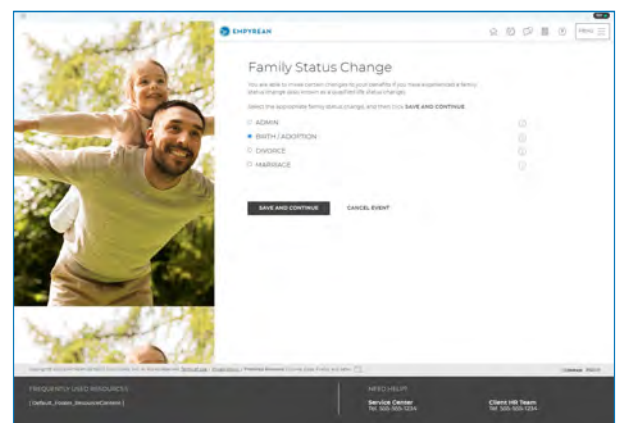


figure 14

Congratulations! You've updated your benefits.

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



UCOR offers **two Flexible Spending Accounts (FSAs)** to help you set aside money (pre-tax) for eligible health care and dependent care expenses – for you and your eligible IRS dependents. The money is deducted from your paycheck before taxes are taken out, just like your medical premiums (or other pre-tax deductions). You can elect to contribute up to the current IRS limits of \$3,400 in the Health Care FSA and up to \$7,500 in the Dependent Care FSA for the 2027 plan year.



ACTION REQUIRED! For the 2027 plan year, current employees must enroll or re-enroll for the Health Care FSA and/or Dependent Care FSA during 2027 Annual Benefits Enrollment. New hires must enroll when eligible for benefits during the new hire enrollment period to participate in FSAs for the current year, and then they must enroll during Annual Benefits Enrollment for the upcoming year.

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

Health Care FSA*

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

Dependent Care FSA

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

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

See how you save

FSAs reduce your taxable income.

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



Susan saves

\$330

22% federal income tax



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

Susan pays \$1,170

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

Note: Health Care FSA contributions may be limited for highly compensated employees (HCE). HCEs are not eligible to participate in the DCFSA. For 2027, the 2026 HCE gross earnings threshold is \$160,000. For more information, visit www.hsabank.com.

*If you elect a Consumer Directed Health Plan (CDHP) option for your 2027 medical coverage, you will not be eligible to elect a Health Care FSA.

READ MORE >

Ready to contribute? Key things to know!

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

Participating in an FSA takes a little planning.

You'll need to think about expenses you may have for each account when deciding how much to contribute. Remember, if you have a Health Care FSA balance left from 2026, it will carry over into 2027, up to the IRS limit. Plus, the IRS has some rules to keep in mind. Here are some key things to know:

- **You don't need to be enrolled in a UCOR medical insurance plan** or any other type of insurance plan in order to participate in the Health Care FSA or Dependent Care FSA.
- **FSAs have a "USE IT OR LOSE IT" rule.** You can incur expenses until the end of the plan year, and you can carry over up to \$680** of your unused balance in your Health Care FSA. Otherwise, will lose any remaining funds left in your account at the end of the plan year.*** Unused funds in your Dependent Care FSA **do not** carry over and will be forfeited at the end of the plan year.
- **Once you enroll in an FSA, you cannot make changes** to the annual contribution unless you have a qualifying mid-year life event. You must initiate your qualified life event change within 31 days of the qualifying event. If you make a mid-year change, you may not elect an amount less than what you have already spent year to date.

Paying for care

Health Care FSA

 **You receive an HSA Bank Debit Card**

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

Dependent Care FSA

 **You have to file a claim for reimbursement**

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

How FSAs work

Health Care FSA					
Elect to Contribute \$1,500	Paycheck contribution \$31.25/paycheck (\$125/month)	\$1,500 available upfront	You fill a prescription; cost is \$50	Use your debit card to pay	Account balance \$1,450
					
Dependent Care FSA					
Elect to Contribute \$1,500	Paycheck contribution \$31.25/paycheck (\$125/month)	\$0 available upfront	Monthly day care invoice \$100	File a claim	Account balance \$25 (until the next paycheck contribution)
					

**Subject to change for 2027, per IRS guidelines.
***The Health Care FSA has a carryover feature for your 2027 dollars, allowing you to carry over up to \$680** of unused funds from 2027 to use toward expenses incurred in 2028. This does not impact how much you can contribute in 2028.

GET ME STARTED >

To enroll in the Health and/or Dependent Care Flexible Spending Accounts, you will need to contact Empyrean at **1-800-451-8964** Monday – Friday, 8 a.m. to 5 p.m. E.T., or online at **MyGroupBenefits-UCOR-ORRCC.com** during 2027 Annual Benefits Enrollment.

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

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

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

How the Plan Works

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

The HSA offers important advantages:



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



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



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



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



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

Who can have an HSA?

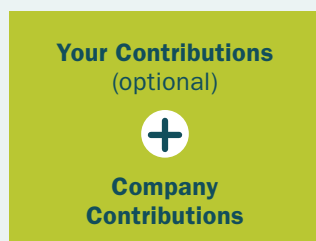
You are eligible to contribute to an HSA if you enroll in either the HSA CDHP Medical Plan or the CDHP Medical Plan, but you will only receive the UCOR contribution to your HSA if you enroll in the HSA CDHP Medical Plan. As a reminder, to receive the UCOR company contribution, you must elect the HSA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

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

How Do the HSA and CDHP Work Together?

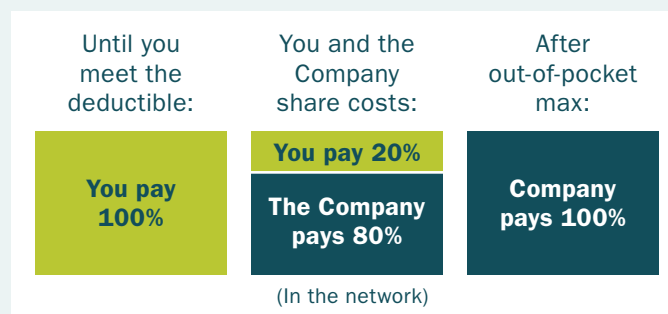
Health Savings Account

You start with contributions to the HSA



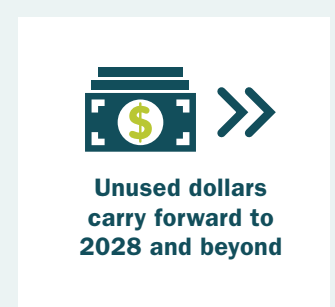
Paying for Care When Needed

You can use your HSA to pay your share of expenses



Carrying Funds Forward

If you have HSA dollars left



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

2027 IRS HSA Contribution Limits

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

If you sign up for coverage for:	You	You and covered family members
UCOR contribution:	\$1,000	\$2,000
You can make additional contributions of:	\$3,500	\$7,000
Total contribution allowed for 2027 (IRS maximum)*:	\$4,500	\$9,000

*You can contribute another \$1,000 if you will be age 55 or older in 2027.

How Can I Use My HSA to Cover My Deductible?

	You only	You plus a spouse or child	You plus your family
Your annual in-network deductible:	\$2,000	\$4,000	\$4,000
UCOR's HSA contribution covers:	– \$1,000	– \$2,000	– \$2,000
To cover your deductible, you can make HSA contributions of:	\$1,000	\$2,000	\$2,000
Part of that can come from what you save in weekly premiums by selecting the HSA CDHP instead of the Medical PPO. You'll save**:	\$275 (\$46.12 – \$40.38 = \$5.74/week x 48)	\$578 (\$96.85 – \$84.81 = \$12.04/week x 48)	\$1,047 (\$142.97 – \$121.16 = \$21.81/week x 48)
Part of it comes from additional contributions from you:	\$725	\$1,422	\$953

**Rounded

WHAT YOU NEED TO KNOW TO ENROLL >

If you elect to contribute \$3,500 for the year (the IRS individual max for 2027, minus the Employer contribution of \$1,000), you'll see a deduction of \$72.91 per paycheck ($\$3,500 / 48 = \72.91). During enrollment, after you elect your medical plan choice, you will need to click "I Agree" on the HSA attestation page to elect the HSA and certify you are eligible to enroll in the plan. You will also need to provide authorization for the account to be opened for you.

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

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



Talk to Doctors When You Need Them



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 **BCBSTNSM** app and choose **Talk to a Doctor Now**, or
- › Visit **bcbst.com/Teladoc**, or
- › Call **1-800-TELADOC (1-800-835-2362)**.

When You Need Mental Health Support



Taking care of your mental health matters. And what affects your mind can also affect your body.

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

**Our mental health team
can connect you with:**

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



We're Here to Help

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

There's no cost to you.

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

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

Extra Support for Your Health Needs



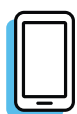
Living with complex conditions is easier with one-on-one help.

Knowing how to stay at your best health and feel good is easier when you have help.

Our care management team is here with just the right amount of extra support and personalized advice you need.

Let us help you:

- › Better understand your health condition(s).
- › Coordinate your care.
- › Find support tools and community resources.
- › Follow your doctor's care plan.
- › Take your medicines correctly, eat right and exercise.
- › Talk with your doctor more easily.
- › Get the most from your benefits.



Get Started

Call us: **1-800-818-8581 (TTY:1-800-848-0298)**, Monday through Friday, 8 a.m. to 7 p.m. ET.



It's always your choice whether to participate. However, some plans require participation to receive full benefits.

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

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. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these 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 Compliance Coordinator; 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>.

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Si usted es miembro, llame al número de Servicio de atención a miembros que figura al reverso de su tarjeta de identificación de Miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالامجان. إذا كنت عضواً، فاتصل برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。若您是會員，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）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Nếu quý vị là hội viên, hãy gọi đến số Dịch vụ Hội viên ở mặt sau thẻ ID Hội viên của quý vị hoặc 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자의 경우, 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 d'aide linguistique vous sont proposés gratuitement. Si vous êtes adhérent, appelez le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou appelez le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ໂປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ຖ້າທ່ານເປັນສະມາຊິກ, ໃຫ້ໂທຫາເບີຂອງຜ່ານບໍລິການສະມາຊິກທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማሳሰቢያ: የጥናትና ቋንቋ አገልግሎት ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። አካል ከሆኑ፣ በአካልነት መታወቂያዎ ጀርባ ላይ በግንኙው የአካልነት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (መስማት ለተሳናቸው፣ TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Falls Sie ein Mitglied sind, rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. જો તમે સભ્ય છો, તો તમારા સભ્ય આઈડી કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કોલ કરો.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。会員のお客様は、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。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Kung ikaw ay isang miyembro, tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng iyong 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 मुफ्त में भाषा सहायता सेवाएँ उपलब्ध हैं। अगर आप सदस्य हैं तो अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर सदस्य सेवा नंबर पर फोन करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Если Вы являетесь участником, 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 گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. در صورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت شناسایی عضو خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Si ou se yon manm, rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Członkowie mogą dzwonić pod numer działu Member Service podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Caso seja membro, ligue para o 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: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Se è un membro, 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).

Díí baa akó nínízin: Díí saad bee yáníłt'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq. Naaltsoos bee ná ha'dít'éego, Naaltsoos Bá Hada'dít'éhígíí ninaaltsoos nítł'íí bee nééhozinígíí bine'déé' Naaltsoos Bá Hada'dít'éhígíí Bee Áka'anída'awo'í bibéesh bee hane'í biká'ígíí bee hodílnih doodago 1-800-565-9140 (Doo Adinits'agóogo q TTY: 1-800-848-0298) bee hodílnih.

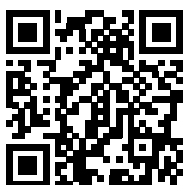
The BCBSTNSM Mobile App: Power in the Palm of Your Hand



The BlueCross BlueShield of Tennessee app makes it easier than ever to get the health information you need, when you need it.

With our fresh, user-friendly design you get:

- › **Live Online Chat:** Get help from a live agent on your care team
- › **All Your Details in One Place:** All your plan coverage and costs up front
- › **Digital ID Card:** See and share your Member ID card with a single tap
- › **Find Care and Costs:** Find providers near you and how much you'll likely pay for their care
- › **Easy Telehealth Access:** Easy-to-find link to make virtual doctor appointments



Scan the QR code or visit the App Store® or Google Play® to download the app for free. Log in using your bcbst.com username and password.



25DIG3467150 (09/25)



Prioritize your wellbeing

Whatever life brings, your program offers expert guidance for you and your family

Connect to care your way



- Reach a licensed clinician by phone 24/7/365 when you call for in-the-moment support
- Access no-cost short-term counseling in person or by video for concerns such as stress, anxiety, depression, burnout or substance use
- Message a Coach to boost your emotional fitness, learn healthy habits, increase resilience and more

Simplify your everyday life with work-life benefits



- Get expert consultations for financial and legal concerns
- Receive referrals for needs such as child or elder care, pet care, home improvement or auto repair



Prefer digital access? No problem!



The web platform and mobile app make it easy to connect to care and strengthen your wellbeing — anytime, anywhere.

- Create a personalized profile for resources tailored to your needs
- Understand your emotions and receive help with mental health check-ins
- Schedule sessions with a licensed clinician via in-person, video or text
- Attend anonymous group sessions for support and connection in a safe, text-based space
- Track your mood and journal to build self-awareness and notice progress

Access guided paths



Follow step-by-step programs on topics such as easing anxiety, building resilience and more with support at every stage of your mental health journey.



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

Log in today to take the next step in your wellbeing journey

888-881-5462

mysupportlinc.com

group code: ucoreap1



Program toolkits

Finding helpful resources can be challenging, especially during difficult times. These interactive toolkits provide practical guidance so you can take action, build resilience and support your mental health—all in one place.



Mental Health Toolkit

Develop skills to identify, understand and respond to signs of mental illness.
www.mentalhealthtoolkit.tools



Critical Incidents Toolkit

Learn practical steps and helpful coping skills to manage the emotional distress that often accompanies these events.
www.criticalincidents.tools



Resiliency Toolkit

Overcome various challenges with resources to apply energy and passion into taking care of yourself.
www.resiliency.tools



Natural Disaster Toolkit

Support emotional wellbeing during disasters, with information on preparedness, communication plans and recovery.
www.naturaldisaster.tools



Mindfulness Toolkit

Discover the benefits of mindfulness, navigate distractions and live fully in the present.
www.mindfulness.tools



Addiction Toolkit

Understand the types of addiction and get the support you need.
www.addictiontoolkit.tools



Meditation Toolkit

Boost self-confidence, empathy, compassion and patience to find peace and clarity.
www.meditate.tools



Supervisor Toolkit

Empower supervisors to lead high-performing teams that boost retention, engagement, performance and career advancement.
www.supervisor.tools



Sleep Fitness Toolkit

Learn habits to get a good night's sleep instead of tossing and turning.



Grief and Loss Toolkit

Equip yourself with support and helpful resources to navigate grief and move forward.
www.griefandloss.tools

Explore a library of tips and tools to boost your overall wellbeing.

888-881-5462

mysupportlinc.com

group code: ucoreap1



United Cleanup Oak Ridge LLC (UCOR)

Health and Welfare Benefit Plan

2027 Annual Benefits Enrollment

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

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

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

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

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

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

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

United Cleanup Oak Ridge LLC (UCOR) Health and Welfare Benefit Plan 2027 Annual Benefits Enrollment

Notice of Special Enrollment Rights

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

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

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

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

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

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

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

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

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

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

UNITED CLEANUP OAK RIDGE LLC (UCOR) HEALTH AND WELFARE 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.
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UNITED CLEANUP OAK RIDGE LLC (UCOR)

HEALTH AND WELFARE 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.

UNITED CLEANUP OAK RIDGE LLC (UCOR) HEALTH AND WELFARE BENEFIT PLAN 2027 Annual Benefits Enrollment

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

United Cleanup Oak Ridge LLC (UCOR)

Health and Welfare Benefit Plan

2027 Annual Benefits Enrollment

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

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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.flmedicaidtprecovery.com/flmedicaidtprecovery.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

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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: HSHIPPProgram@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

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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:

United Cleanup Oak Ridge LLC (UCOR)

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

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

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

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

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

Uses and Disclosures of PHI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authorizations

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

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

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

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

Individual Rights

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

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

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

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

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

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

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

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

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

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

QUESTIONS AND COMPLAINTS

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

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

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

Implementation Date: October 28, 2019
Last revised: May 1, 2023



Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.¹²

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name United Cleanup Oak Ridge LLC (UCOR)		4. Employer Identification Number (EIN) 85-2867528	
5. Employer address P.O. BOX 4699, MS 7402		6. Employer phone number 865-576-9206	
7. City OAK RIDGE	8. State TN	9. ZIP code 37831	
10. Who can we contact about employee health coverage at this job? UCOR-ORRCC Benefits Service Center			
11. Phone number (if different from above)		12. Email address benefits@orcc.doe.gov	

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

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

All employees. Eligible employees are:

☐☒

Some employees. Eligible employees are:

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

- With respect to dependents:

☒

We do offer coverage. Eligible dependents are:

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

☐

We do not offer coverage.

☒

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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

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

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ \$135.92

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

United Cleanup Oak Ridge LLC (UCOR) Health and Welfare Benefit Plan 2027 Annual Benefits Enrollment



YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

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

then an employer may not deny you:

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

because of this status.

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

HEALTH INSURANCE PROTECTION

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

ENFORCEMENT

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

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



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



U.S. Department of Justice



Office of Special Counsel



1-800-336-4890

Publication Date — July 2026



of Tennessee: Large Group Medical United Cleanup Oak Ridge LLC (UCOR) (OPT#1)

Coverage for: Individual or Family | Plan Type: PPO



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 <u>deductible</u> ?	In-network: \$400 person/\$800 family Out-of-network: \$1,000 person/\$2,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive services</u> , <u>Office visits</u> , and <u>Emergency room visits</u> are covered before you meet your <u>deductible</u> (unless specified).	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$200 individual/\$400 family Pharmacy only Deductible. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-network: \$5,100 person/\$10,200 family Out-of-network: \$13,200 person/\$26,400 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billing charges</u> , <u>penalties</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Teladoc Health: \$30 <u>copay</u>
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Office surgery subject to office visit <u>copay</u> .
	<u>Preventive care</u> /screening/ immunization	No Charge	40% <u>coinsurance</u>	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	40% <u>coinsurance</u>	Diagnostic testing benefits are determined by place of service, such as office or ER. <u>Copay</u> applies if filed with an office visit.
	Imaging (CT/PET scans, MRI(s))	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition	Preferred Generic drugs / Non-Preferred Generic drugs	\$10 <u>copay</u> /prescription after pharmacy <u>deductible</u>	20% <u>coinsurance</u>	30 day supply for Retail Network; 2.5x <u>copay</u> up to 90 day supply for Home Delivery or Plus90 Network for Non-Preventive drugs.
	Preferred brand drugs	\$35 <u>copay</u> /prescription after pharmacy <u>deductible</u>	20% <u>coinsurance</u>	\$10/\$35/\$60 <u>copay</u> per 30 day supply and \$25/\$87.50/\$150 <u>copay</u> per 90 day supply for Preventive drugs – <u>deductible</u> does not apply.
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription after pharmacy <u>deductible</u>	20% <u>coinsurance</u>	Out-of-Network Preventive drugs are not covered.

*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)	
More information about <u>prescription drug</u> coverage is available at www.bcbst.com/rxp or contact us at 800-565-9140	Preferred <u>Specialty drugs</u> / Non-Preferred <u>Specialty drugs</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network. Up to \$400 maximum.
	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay/visit deductible</u> does not apply.	40% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
If you have outpatient surgery	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	<u>Emergency room care</u>	\$200 <u>copay/visit deductible</u> does not apply.	\$200 <u>copay/visit deductible</u> does not apply.	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	\$200 <u>copay/deductible</u> does not apply.	\$200 <u>copay/deductible</u> does not apply.	None
	<u>Urgent care</u>	\$75 <u>copay/visit deductible</u> does not apply.	40% <u>coinsurance</u>	Office surgery subject to office visit <u>copay</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay/visit deductible</u> does not apply.	\$300 <u>copay/admission</u> then 40% <u>coinsurance</u> after <u>deductible</u> .	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No Charge	40% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.

*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 mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay/visit deductible</u> does not apply for office visits.	40% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Inpatient services	\$100 <u>copay/admission deductible</u> does not apply.	\$300 <u>copay/admission</u> then 40% <u>coinsurance</u> after deductible.	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	\$30 <u>copay/visit deductible</u> does not apply.	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$100 <u>copay/visit deductible</u> does not apply.	\$300 <u>copay/admission</u> then 40% <u>coinsurance</u> after deductible.	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Unlimited
	<u>Rehabilitation services</u>	\$45 <u>copay/visit deductible</u> does not apply.	40% <u>coinsurance</u>	Therapy visits include acupuncture, chiropractic, physical, speech and occupational - limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	\$45 <u>copay/visit deductible</u> does not apply.	40% <u>coinsurance</u>	Therapy visits include acupuncture, chiropractic, physical, speech and occupational - limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Skilled nursing care</u>	\$100 <u>copay/admission deductible</u> does not apply.	\$300 <u>copay/admission</u> then 40% <u>coinsurance</u> after deductible.	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 50% if not obtained. *See Prior Authorization section.

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

If your child needs dental or eye care	<u>Hospice services</u>	Inpatient: \$100 copay/admission deductible does not apply - Outpatient: 20% coinsurance.	Inpatient: \$300 copay/admission then 40% coinsurance after deductible Outpatient: 40% coinsurance.	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
	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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Hearing aids for adults	• 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	• 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 non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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&dsid=-8432>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this plan provide Minimum Essential Coverage? Yes.

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

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

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$400
Copayments	\$400
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,820

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

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

Total Example Cost	\$5,600
--------------------	---------

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles*	\$400
Copayments	\$245
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$1,875

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$400
Copayments	\$245
Coinsurance	\$480
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,125

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services"?

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

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 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 0018, Chattanooga, TN 37402-0019; (423) 591-0208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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.

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an Independent Licensee of the BlueCross
BlueShield Association.

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

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).

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

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. ກະລຸນາໃຫ້ທ່ານເບິ່ງຂອງຜ່ານບໍລິການສະມາຊິກ
ທີມີຢູ່ດ້ານທີ່ບັດ ID ສະມາຊິກຂອງທ່ານ ທີ່
1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ገጽ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለአርስዎ ይገኛሉ። በአገልገት መተወደዎዎ ጆርገላይ በሚገኘው የአገላለጽ አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

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

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. در صورتیکه 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'ÁKOHWIIINIDZIN: Diné bizaad
bee yańil'tigo, t'áá jilk'eh saad bee
áka'aná'awo' bee áka'anida'awo' dóo
t'áadoole'eh binahij' bee adahodoonil'tij
dine bich'í' anidahazt'í' bee
bika'aanida'awo'í ná dahóló. T'áá shóodí
Bil ha'dit'ehí Bika'aná'awo' Bil ha'dit'ehí
I naaltsoos nit'ízi bine'dé' binamboo
bee hodiliin doodago 1-800-565-9140
(TTY: 1-800-848-0298).

WICHDIICH: Wann du Deitsch schwetzsch
un brauchsch Hilf fer communicat-e kenne
mer dich helfe unni as es dich ennich epes
koschde zellt. Mir kenne differnti Sadde
Schprooch-Hilf beigrigee aa fer nix. Ruf
der Member Service Number uff die hinerscht.
Seit vun der 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 avanua mo oe auuaua fesoasoani mo gagana e auua ma se tologi faapea ma fesoasoani fa'aopo'opo ma auuauaga talafaeagi. Faamolemole vala'au le numera o le Member Service (Auuauaga 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 dare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSIÓN: Guaha setbisio siha para hãgu yanggen fifino' CHamoru hao, dibátde na setbisión inayudon fumino' CHamoru yan propriu na inasisten trastes yan setbisio siha. Put fabot ágang i numiron Setbisión Membre gí tantattan i katta-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

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



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 <u>deductible</u> ?	In-network: \$2,000 individual/\$4,000 family Out-of-network: \$4,000 individual/\$8,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this plan begins to pay. If you have other family members on the <u>plan</u> , the overall family deductible must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	In-network: \$4,500 individual/\$9,000 family Out-of-network: \$9,000 individual/\$18,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billing</u> charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of <u>in-network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

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

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Teladoc Health: \$45 <u>copay</u>
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>coinsurance</u>	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	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 <u>prescription drug coverage</u> is available at www.bcbst.com/cxp or contact us at 800-565-9140	Preferred Generic drugs / Non-Preferred Generic drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. Preventive drugs: Generic & Preferred brand: 30-day: 20% up to \$200 max; 60-day: 20% up to \$400 max; 90-day: 20% up to \$600 max; Non-preferred brand: 30-day: 30% up to \$200 max; 60-day: 30% up to \$400 max; 90-day: 30% up to \$600 max
	Preferred brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Non-preferred brand drugs	20% <u>coinsurance</u>	30% <u>coinsurance</u>	

*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	Preferred Specialty drugs / Non-Preferred Specialty drugs	20% <u>coinsurance</u>	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Outpatient services	Office and other outpatient 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing does not apply for preventive services.</u>
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	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.

*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	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Unlimited
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy visits include acupuncture, chiropractic, physical, speech, and occupational - limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
- Bariatric surgery - Cosmetic surgery - Dental care (Adult) - Dental care (Children) - Hearing aids for adults	- 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 (Children) - Routine foot care for non-diabetics - Weight loss programs - Home childbirth delivery - Routine eye care (Adult)
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.cchio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

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

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$4,120

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$2,630

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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

BlueCross:

- 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 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) 591-0208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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

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

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).

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

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 전화하십시오.

ເອົາໃຈໃສ່ ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການ
ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່
ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂຕກາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ
ທີມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ທີ່
1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፤ ገጽ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለአርስዎ ይገኛሉ። በአገልገት መተወደዎዎ ጀርባ ላይ በሚገኘው የአገልግሎት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

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

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. در صورتیکه 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'ÁKOHWIIINIDZIN: Diné bizaad bee yańil'tigo, t'áá jilk'eh saad bee áka'aná'awo' bee áka'anida'awo' dóo t'áadoole'eh binahij' bee adahodoońil'tigí díné bich'í' anidahazt'í'í bee bika'aanida'awo'í ná dahóló. T'áá shóodí Bih'ha'dit'ehí Bika'aná'awo' Bih'ha'dit'ehí ID naaltsoos nit'ł'iz bine'dé' binamboo bee hoodiil'ini doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDIICH: Wann du Deitsch schwetzscht
un brauchstich 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 hinerscht!
Seit vun der 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 avanua mo oe auauanaga fesoasoani mo gagana e auuaa ma se fotogi faapea ma fesoasoani fa'aopo'opo ma auauanaga talafaeagai. 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 yelug liugul tagurul Member ID kard la yam dare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSIÓN: Guaha setbisio siha para hagu
yanggen fifino' CHamoru hao, dibátde na
setbisio inayudon fumino' CHamoru yan
propriu na inasisten trastes yan setbisio siha.
Put fabot ágang i numiron Setbision Membri
gi santantan i katta-mu Member ID pat
1-800-565-9140 (TTY: 1-800-848-0298).

24COM2787903 NDMLI-10 15 24 (10/24)



of Tennessee : Large Group Medical United Cleanup Oak Ridge LLC (UCOR)(OPT#3)

Coverage for: Individual or Family | Plan Type: HDHP



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 at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall shared deductible?	In-network: \$3,500 person/ \$7,000 family Out-of-network: \$5,000 person/\$10,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the embedded out-of-pocket limit for this plan?	In-network: \$7,000 person/\$14,000 family Out-of-network: \$14,000 person/\$28,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billing</u> charges, <u>penalties</u> , and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a 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 <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.

 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% <u>coinsurance</u>	50% <u>coinsurance</u>	Teladoc Health: \$45 <u>copay</u>
	Specialist visit	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge	50% <u>coinsurance</u>	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% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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 <u>prescription drug coverage</u> is available at www.bcbst.com/rxp	Preferred Generic drugs / Non-Preferred Generic drugs	30% <u>coinsurance</u>	30% <u>coinsurance</u>	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% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Non-preferred brand drugs	45% <u>coinsurance</u>	45% <u>coinsurance</u>	

*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	Preferred <u>Specialty drugs</u> / Non-Preferred <u>Specialty drugs</u>	30% <u>coinsurance</u> / 45% <u>coinsurance</u>	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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% <u>coinsurance</u>	50% <u>coinsurance</u>	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	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing does not apply for preventive services.</u>
	Childbirth/delivery professional services	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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

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

	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	None	
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
If you need help recovering or have other special health needs	<u>Home health care</u>	50% coinsurance	50% coinsurance	Unlimited	
	<u>Rehabilitation services</u>	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.	
	<u>Habilitation services</u>	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.	
	<u>Skilled nursing care</u>	50% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.	
	<u>Durable medical equipment</u>	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.	
	<u>Hospice services</u>	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	

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

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> 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 condition - 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
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> 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.ccio.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.

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

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.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.

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,700
What isn't covered	
Limits or exclusions	\$20
The total the family would pay is	\$7,220

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$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.

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United Cleanup Oak Ridge LLC (UCOR)

Health and Welfare Benefit Plan

2027 Annual Benefits Enrollment

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 balance 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

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

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

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

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

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

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

**SUMMARY ANNUAL REPORT
FOR
UNITED CLEANUP OAK RIDGE HEALTH AND WELFARE BENEFIT PLAN**

This is a summary of the annual report of the United Cleanup Oak Ridge Health and Welfare Benefit Plan (Employer Identification Number 85-2867528, Plan Number 501) for 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).

Insurance Information

The plan has insurance contracts with BlueCross BlueShield of Tennessee, Inc., Cigna Health and Life Insurance Company and Affiliates, Vision Service Plan and Zurich American Insurance Company to pay certain health, prescription drug, dental, vision and business travel accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were \$21,728,136.

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 \$20,417,400 and the total of all benefit claims paid under this experience-rated contract during the plan year was \$20,173,938.

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 PO 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.

