



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, visit [www.includedhealth.com/lubrizol](http://www.includedhealth.com/lubrizol) or by calling 1-855-431-5532. 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 [www.includedhealth.com/lubrizol](http://www.includedhealth.com/lubrizol) or call 1-855-431-5532 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <u>network provider</u> *: \$3,250 Individual / \$4,875 Individual Plus 1/ \$6,500 Family For out-of- <u>network</u> providers*: \$3,250 Individual / \$4,875 Individual Plus 1/ \$6,500 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No, there are no other <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <u>network provider</u> *: \$4,750 Individual / \$6,375 Individual Plus 1/ \$8,000 Family For out-of- <u>network</u> providers*: \$4,750 Individual / \$6,375 Individual Plus 1/ \$8,000 Family per calendar year. * <u>Out-of-pockets</u> cross-apply	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.includedhealth.com/lubrizol">www.includedhealth.com/lubrizol</a> or call 1-855-431-5532 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



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 (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	Virtual visit - In network 20% <a href="#">coinsurance</a> [after deductible] by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional <a href="#">copayments</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.
	<a href="#">Specialist</a> visit	20% Coinsurance	40% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	No charge; Deductible Waived	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>.</p>	Generic drugs (Tier 1)	Retail: 10% coinsurance Mail Order: 10% coinsurance Preventive drugs: No Charge (deductible does not apply)	Retail: 10% coinsurance Mail Order: 10% coinsurance Preventive drugs: No Charge (deductible does not apply)	Up to 30-day retail supply; 31-90-day mail/ Maintenance Choice. Erectile dysfunction drugs are limited to six doses per month. Limits apply to compound drugs and Opioid products. Certain drugs with limited clinical value and clinically appropriate, lower-cost alternatives excluded. Prior authorization for certain drugs required.
	Preferred brand drugs (Tier 2)	Retail: 20% coinsurance Mail Order: 20% coinsurance	Retail: 20% coinsurance Mail Order: 20% coinsurance	Up to 30-day retail supply; 31-90-day mail/Maintenance Choice. Limitations and exclusions described for generic drugs apply. You may be required to try generic drug(s) or obtain prior authorization first to receive coverage. Prior authorization for certain drugs required.
	Non-preferred brand drugs (Tier 3)	Retail: 30% coinsurance Mail Order: 30% coinsurance	Retail: 30% coinsurance Mail Order: 30% coinsurance	
	<a href="#">Specialty drugs</a> (Tier 4)	Retail: Not covered Mail Order: 35% coinsurance	Retail: Not covered Mail Order: 35% coinsurance	Specialty/Biotech available only by mail. Limitations and exclusions described for generic drugs apply. You may be required to try generic drug(s) or obtain prior authorization first to receive coverage. Prior authorization for certain drugs required.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
<p><b>If you need immediate</b></p>	<a href="#">Emergency room care</a>	20% Coinsurance	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
medical attention	<a href="#">Emergency medical transportation</a>	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or \$500 penalty
	<a href="#">Urgent care</a>	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service for Out-of-network only.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or \$500 penalty.
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. Limit of 120 days per calendar year.
	<a href="#">Rehabilitation services</a>	20% Coinsurance	40% Coinsurance	None
	<a href="#">Habilitation services</a>	20% Coinsurance	40% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	<a href="#">Skilled nursing care</a>	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. Limit of 120 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% Coinsurance	40% Coinsurance	Prior Authorization required for DME devices in excess of \$500 for rentals or \$1,500 for purchases or \$500 penalty.
	<a href="#">Hospice service</a>	20% Coinsurance	40% Coinsurance	Prior Authorization required for out of <u>network</u> hospice in-patient only or penalty of \$500 applies.
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	40% Coinsurance	Covered if due to medical diagnosis.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Adult routine vision exam (i.e. refraction)</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Certain Pain Patches</li><li>• Long-term care</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Child dental check-up</li><li>• Child vision glasses</li><li>•</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Acupuncture (in lieu of anesthesia)</li><li>• Chiropractic care (20 visits per year limit)</li><li>• Bariatric Surgery (must obtain prior authorization and use COE)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (\$500 limit every two years)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Infertility treatment (must use COE; \$25,000 lifetime maximum)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care (as part of treatment for severe diabetes)</li><li>• Weight loss programs</li></ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). 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](http://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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://www.HealthCare.gov) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### Does this [plan](#) Provide Minimum Essential Coverage? Yes

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

### Does this [plan](#) Meet the Minimum Value Standard? Yes

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

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-431-5532.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-431-5532.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-431-5532.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-431-5532.

*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](#) \$3,250
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*pre-natal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist visit](#) (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,810</b>

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

- The [plan's](#) overall [deductible](#) \$3,250
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$3,250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,670</b>

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

- The [plan's](#) overall [deductible](#) \$3,250
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,570</b>