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, https://benefits.lubrizol.com or call 1-866-799-2731. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-877-706-1735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,250** Individual / **$4,875** Individual Plus 1 / **$6,500** Family / Combined Network and Non-Network covered services per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care is covered before you meet your deductible. COVID-19 testing and testing-related visits for so long as required by applicable law; Virtual Network Provider Visits on or before 1/20/21 with COVID-19 Diagnosis will be reimbursed.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,750** Individual / **$6,375** Individual Plus 1 / **$8,000** Family -- Combined Network and Non-Network covered service expenses per year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	**Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.**	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-877-706-1735 for a list of network providers in the UnitedHealthcare Choice Plus Network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 COVID-19-related testing (For so long as required by applicable law)	20% Coinsurance No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	Designated Virtual Network Provider covered at 20% coinsurance per visit (after deductible) (no coinsurance/deductible for Virtual Network Provider visits through1/20/21 with COVID-19 Diagnosis). No virtual visit coverage for non-network. If you receive services in addition to office visit, additional copayments, deductibles, or coinsurance may apply.
	Specialist visit COVID-19-related testing (For so long as required by applicable law)	20% Coinsurance No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	Infertility coverage limited to $25,000 lifetime maximum. Hearing exams/equipment limited to $500 every 2 years.
	Preventive care/screening/ immunization	No Charge Deductible does not apply	No Charge Deductible does not apply	Includes preventive health services specified in the health care reform law. 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work) COVID-19-related testing (For so long as required by applicable law)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, Women's Health, and Orthopedic Health Support. For obesity surgery or infertility services to be considered covered health services, you must enroll in the applicable centers of excellence program at 1-877-706-1735. Infertility coverage limited to $25,000 lifetime maximum.
	Imaging (CT/PET scans, MRIs) COVID-19-related testing (For so long as required by applicable law)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, Women's Health, and Spine and Joint Solution. For obesity surgery or infertility services to be considered covered health services, you must enroll in the applicable centers of excellence program at 1-877-706-1735. Infertility coverage limited to $25,000 lifetime maximum.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com** or by calling 1-844-742-5087.	Generic drugs (Tier 1)	Retail: 10% Coinsurance Mail Order: 10% Coinsurance Preventive maintenance: No Charge (deductible does not apply)	Retail: 10% Coinsurance Mail Order: 10% Coinsurance Preventive maintenance: 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. Infertility drugs are subject to a $15,000 lifetime limit. Limits apply to compound drugs. Certain pain patches are excluded. First fill limit of seven days for immediate release, new, acute opioid prescriptions for plan members with no history of prior opioid use. Quantity of opioid products prescribed limited to 90 MME per day. Opioid products containing acetaminophen, aspirin, or ibuprofen limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day. Use of an immediate-release opioid formulation will be required before moving to an extended-release opioid formulation. Patients age 19 years and younger limited to no more than a three-day supply of short acting opioids.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com** or by calling 1-844-742-5087.	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) first to receive coverage.
	Non-preferred brand drugs (Tier 3)	Retail: 30% Coinsurance Mail Order: 30% Coinsurance	Retail: 30% Coinsurance Mail Order: 30% 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) first to receive coverage.
	Specialty drugs (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) first to receive coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, Women's Health, and Spine and Joint Solution. For obesity surgery or infertility services to be considered covered health services, you must enroll in the applicable COE at 1-877-706-1735. Infertility coverage limited to $25,000 lifetime maximum.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care Authorized and approved COVID-19 testing and testing-related visits (For so long as required by applicable law)	20% Coinsurance No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	Prior Authorization required for Non-Network or $500 penalty.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None.
	Urgent care COVID-19 testing and testing-related visits (For so long as required by applicable law)	20% Coinsurance No Charge Deductible does not apply	20% Coinsurance No Charge Deductible does not apply	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, Women's Health, and Spine and Joint Solution. For obesity surgery or infertility services to be considered covered health services, you must enroll in the applicable centers of excellence program at 1-877-706-1735. Infertility coverage limited to $25,000 lifetime maximum.
If you have a hospital stay	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, Women's Health, and Spine and Joint Solution. For obesity surgery or infertility services to be considered covered health services, you must enroll in the applicable centers of excellence program at 1-877-706-1735. Infertility coverage limited to $25,000 lifetime maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	20% Coinsurance	20% Coinsurance	3 No Cost EAP in-person visits.
	Inpatient services	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
If you are pregnant	Office visits	20% Coinsurance	20% Coinsurance	Routine pre-natal care covered at no charge. Prior Authorization required for Non-Network inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or $500 penalty.
	Childbirth/delivery professional services	20% Coinsurance	20% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	20% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. Limit of 120 days per calendar year.
	Rehabilitation services	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network in-patient rehabilitation facility or $500 penalty.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. Limit of 120 days per calendar year.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	Prior Authorization required for DME devices that cost more than $1,000 or $500 penalty. Hearing exams/equipment limited to $500 every 2 years.
	Hospice services	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	20% 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Child dental check-up	• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.
• Child vision glasses	• Habilitation services	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
		• Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Infertility coverage
• Bariatric Surgery	• Hearing aids	• Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-877-706-1735 or visit http://benefits.lubrizol.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-706-1735.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-706-1735.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-706-1735.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-706-1735.]

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

* For more information about limitations and exceptions, see the plan or policy document at https://benefits.lubrizol.com/spd.

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 *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,250
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,750**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,250
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,750**

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 test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

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

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