UMR: THE LUBRIZOL CORPORATION: 7670-00-415412 Plus Plan

Coverage for: Individual, Individual+1, 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, visit 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 or call 1-855-431-5532 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network*: $2,250 Individual / $3,375 Individual Plus 1 / $4,500 Family Non-Network*: $2,250 Individual / $3,375 Individual Plus 1 / $4,500 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, 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 services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	For network provider*: $3,750 Individual / $4,875 Individual Plus 1 / $6,000 Family For out-of-network providers*: $3,750 Individual /$4,875 Individual Plus 1 / $6,000 Family per calendar year *Out-of-pockets cross-apply	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?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.includedhealth.com/lubrizol or call 1-855-431-5532 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	Virtual visit - In network 20% coinsurance [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 copayments, deductibles, or coinsurance may apply.
	Specialist visit	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	No charge; Deductible Waived	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.
If you have a test	Diagnostic test (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)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com.	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	
	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) or obtain prior authorization first to receive coverage. Prior authorization for certain drugs required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate	Emergency room care	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	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization, 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	
	Inpatient services	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance 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	

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)	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. Limit of 120 days per calendar year
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. Limit of 120 days per calendar year.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior Authorization required for DME devices in excess of $500 for rentals or $1,500 for purchases or $500 penalty.
	Hospice service	20% Coinsurance	40% Coinsurance	Prior Authorization required for out of network 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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Adult routine vision exam (i.e. refraction) • Cosmetic surgery • Dental care (Adult)	• Certain Pain Patches • Long-term care • Private-duty nursing	• Child dental check-up • Child vision glasses

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (in lieu of anesthesia) • Chiropractic care (20 visits per year limit) • Bariatric Surgery (must obtain prior authorization and use COE)	• Hearing aids ($500 limit every two years) • Non-emergency care when traveling outside the U.S. • Infertility treatment (must use COE; $25,000 lifetime maximum)	• Routine foot care (as part of treatment for severe diabetes) • Weight loss programs

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. 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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, kwiijigo 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**	**$2,250**
■ **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,250
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,810**

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

■ **The plan's overall deductible**	**$2,250**
■ **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*	$2,250
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,870**

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

■ **The plan's overall deductible**	**$2,250**
■ **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,250
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,350**

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