Lubrizol Consumer Driven Health Plan - Core

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee /Employee+1/ 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 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?	**$4,000** Individual / **$6,000** Individual Plus 1 / **$8,000** 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.	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?	**$5,500** Individual / **$7,500** Individual Plus 1** / **$9,500** Family** -- Combined Network and Non-Network covered service expenses per year**Individual Plus 1 and Family coverage have an individual cap of $5,500. If any one family member reaches the individual cap of $5,500, that person's covered expenses will be covered at 100% for the rest of the plan 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.

Important Questions	Answers	Why This Matters:
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	20% Coinsurance	40% Coinsurance	Designated Virtual Network Provider covered at 20% coinsurance per visit (after deductible). 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	20% Coinsurance	40% Coinsurance	None.
	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.

If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network Sleep Studies or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
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 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. 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.
	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. Limits apply to compound drugs. You may be required to try generic drug(s) first to receive coverage. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
	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. Erectile dysfunction drugs are limited to six doses per month. Infertility drugs are subject to a $15,000 lifetime limit. Certain drugs require prior authorization including androgens, anabolic steroids, and lidocaine (post-limit). Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None.
	Urgent care	20% Coinsurance	40% Coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	

If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	3 No Cost EAP in person visits.
	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	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	40% Coinsurance	
	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. 120 visit limit/calendar year.
	Rehabilitation services	20% Coinsurance	40% 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	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 that cost more than $1,000 or $500 penalty.
	Hospice services	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Routine eye care (Adult)
- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- 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 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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	$4,000
■ 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,560**

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

■ The plan's overall deductible	$4,000
■ 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$669
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,724**

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

■ The plan's overall deductible	$4,000
■ 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Lubrizol Consumer Driven Health Plan - Standard

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee /Employee+1/ 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 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?	**$3,000** Individual / **$4,500** Individual Plus 1 / **$6,000** 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.	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?	**$4,500** Individual / **$6,000** Individual Plus 1 / **$7,500** 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.

Important Questions	Answers	Why This Matters:
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	20% Coinsurance	40% Coinsurance	Designated Virtual Network Provider covered at 20% coinsurance per visit (after deductible). 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	20% Coinsurance	40% Coinsurance	None.
	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.

If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network Sleep Studies or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
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 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. 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.
	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. Limits apply to compound drugs. You may be required to try generic drug(s) first to receive coverage. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
	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. Erectile dysfunction drugs are limited to six doses per month. Infertility drugs are subject to a $15,000 lifetime limit. Certain drugs require prior authorization including androgens, anabolic steroids, and lidocaine (post-limit). Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None.
	Urgent care	20% Coinsurance	40% Coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	

If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	3 No Cost EAP in person visits.
	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	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	40% Coinsurance	
	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. 120 visit limit/calendar year.
	Rehabilitation services	20% Coinsurance	40% 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	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 that cost more than $1,000 or $500 penalty.
	Hospice services	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Routine eye care (Adult)
- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- 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 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:

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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.

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**	**$3,000**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

■ **The plan's overall deductible**	**$3,000**
■ **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$869
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,924**

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

■ **The plan's overall deductible**	**$3,000**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Lubrizol Consumer Driven Health Plan - Plus

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee /Employee+1/ 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 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?	**$2,000** Individual / **$3,000** Individual Plus 1 / **$4,000** 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.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But 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?	**$3,500** Individual / **$4,500** Individual Plus 1 / **$5,500** 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.

Important Questions	Answers	Why This Matters:
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	20% Coinsurance	40% Coinsurance	Designated Virtual Network Provider covered at 20% coinsurance per visit (after deductible). 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	20% Coinsurance	40% Coinsurance	None.
	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.

If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network Sleep Studies or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
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 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. 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.
	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. Limits apply to compound drugs. You may be required to try generic drug(s) first to receive coverage. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
	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. Erectile dysfunction drugs are limited to six doses per month. Infertility drugs are subject to a $15,000 lifetime limit. Certain drugs require prior authorization including androgens, anabolic steroids, and lidocaine (post-limit). Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None.
	Urgent care	20% Coinsurance	40% Coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	40% Coinsurance	

If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	3 No Cost EAP in person visits.
	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	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	40% Coinsurance	
	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. 120 visit limit/calendar year.
	Rehabilitation services	20% Coinsurance	40% 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	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 that cost more than $1,000 or $500 penalty.
	Hospice services	20% Coinsurance	40% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Routine eye care (Adult)
- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- 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 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,069
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,124**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

UnitedHealthcare

Lubrizol Out-of-Area (OOA) Plan

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee /Employee+1/ 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 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?	**$750** Individual / **$1,500** Individual Plus 1 / **$2,150** 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 and categories with copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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 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?	**$2,250** Individual / **$4,500** Individual Plus 1 / **$6,750** 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.

Important Questions	Answers	Why This Matters:
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 Options PPO Network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You can receive covered services from any provider.
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	20% Coinsurance	20% Coinsurance	Designated Virtual Network Provider covered at 20% coinsurance per visit (after deductible). 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	20% Coinsurance	20% Coinsurance	None.
	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.

If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	Prior Authorization required for Non-Network Sleep Studies or $500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
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 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. 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.
	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. Limits apply to compound drugs. You may be required to try generic drug(s) first to receive coverage. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
	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. Erectile dysfunction drugs are limited to six doses per month. Infertility drugs are subject to a $15,000 lifetime limit. Certain drugs require prior authorization including androgens, anabolic steroids, and lidocaine (post-limit). Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.
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, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	
If you need immediate medical attention	Emergency room care	$150 Copay/visit, 20% Coinsurance	$150 Copay/visit, 20% Coinsurance	Prior Authorization required for Non-Network or $500 penalty.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None.
	Urgent care	20% Coinsurance	20% Coinsurance	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, and Spine and Joint Solution. For obesity surgery to be considered a covered health service, you must contact Bariatric Resource Services at 1-877-706-1735.
	Physician/surgeon fees	20% Coinsurance / 10% Coinsurance for Centers of Excellence Services	20% Coinsurance	

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. 120 visit limit/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.
	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.)

- Routine eye care (Adult)
- Child dental check-up
- Child vision glasses
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- 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 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. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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**	**$750**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,310**

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

■ **The plan's overall deductible**	**$750**
■ **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,196
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,001**

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

■ **The plan's overall deductible**	**$750**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,135**

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