




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:
<p><u>What is the overall deductible?</u></p>	<p><u>Network</u>*: \$2,250 Individual** / \$3,500 Individual Plus 1 / \$4,750 Family <u>Non-Network</u>*: \$2,250 Individual** / \$3,500 Individual Plus 1 / \$4,750 Family per calendar year. Does not apply to services listed below as "No Charge". *<u>Deductible</u> cross-apply **Does not apply if policy covers more than one person.</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>Preventive Care</u> is covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific service, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>
<p><u>What is the out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>Medical- <u>Network</u>*: \$3,750 Individual** / \$5,500 Individual Plus 1 / \$7,250 Family <u>Non-Network</u>*: \$3,750 Individual** / \$5,500 Individual Plus 1 / \$7,250 Family per calendar year *<u>Out-of-pockets</u> cross-apply ** Does not apply if policy covers more than one person.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, the overall family <u>out-of-pocket limits</u> must be met.</p>
<p><u>What is not included in the out-of-pocket limit?</u></p>	<p><u>Premiums</u>, <u>balance-billing charges</u>, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

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

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Designated Virtual <u>Network Provider</u> covered at 20% <u>coinsurance</u> per visit (after deductible). No virtual visit coverage for non- <u>network</u> . If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	Prior Authorization required Non- <u>Network</u> for Sleep Studies or \$500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	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 <u>prescription drug coverage</u> is available at <u>www.caremark.com</u>	Generic Drugs (Tier 1)	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	Retail: 20% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Retail: 30% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Up to 30-day retail supply; 31-90-day mail/Maintenance Choice. You may be required to try generic drug(s) first to receive coverage. Limits apply to compound drugs. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Specialty drugs (Tier 4)	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
	<u>Urgent care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	3 No Cost EAP in person visits.
	Inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
If you are pregnant	Office visits	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Routine pre-natal care covered at no charge. Prior Authorization required for Non- <u>Network</u> inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or \$500 penalty.
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. 120 visit limit/calendar year.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> inpatient rehabilitation facility or \$500 penalty.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. Limit of 120 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for DME devices that cost more than \$1,000 or \$500 penalty.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
If your child needs dental or eye care	Children's eye exam	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	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:

<u>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</u>		
<ul style="list-style-type: none"> • Adult routine vision exam (i.e. refraction) • Child dental check-up • Child vision glasses • Cosmetic Surgery 	<ul style="list-style-type: none"> • Dental Care (Adult) • <u>Habilitation services</u> • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Private-duty nursing • Weight loss programs
<u>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</u>		
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • 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, kwijigo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall deductible	\$2,250	■ The <u>plan's</u> overall deductible	\$2,250	■ The <u>plan's</u> overall deductible	\$2,250
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic tests</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,250	<u>Deductibles</u>	\$2,250	<u>Deductibles</u>	\$1,305
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500	<u>Coinsurance</u>	\$1,196	<u>Coinsurance</u>	\$385
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$3,810	The total Joe would pay is	\$3,501	The total Mia would pay is	\$1,690




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Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>Network</u>: \$750 Individual* / \$1,500 Individual Plus 1 / \$2,150 Family</p> <p><u>Non-Network</u>: Not Covered per calendar year. Does not apply to <u>copayments</u>, and services listed below as "No Charge."</p> <p>*Does not apply if policy covers more than one person.</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
Are there services covered before you meet your deductible?	<p>Yes. <u>Preventive Care</u> and categories with <u>copayments</u> are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/</p>
Are there other deductibles for specific services?	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific service, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>
What is the out-of-pocket limit for this plan?	<p>Medical- <u>Network</u>: \$2,250 Individual* / \$4,500 Individual Plus 1 / \$6,750 Family per calendar year</p> <p><u>Non-Network</u>: Not Covered</p> <p>*Does not apply if policy covers more than one person.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, the overall family <u>out-of-pocket limits</u> must be met.</p>
What is not included in the out-of-pocket limit?	<p><u>Premiums</u>, <u>balance-billing charges</u>, health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

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

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> /visit. <u>Deductible</u> does not apply.	Not Covered	Designated Virtual <u>Network Provider</u> covered at 100% after \$20 <u>copay</u> per visit. No virtual visit coverage for non- <u>network</u> . If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	\$30 <u>Copay</u> /visit. <u>Deductible</u> does not apply.	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge. <u>Deductible</u> does not apply.	Not Covered	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	No non- <u>network</u> coverage. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	No non- <u>network</u> coverage. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.caremark.com</u></p>	Generic Drugs (Tier 1)	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	Retail: 20% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Retail: 30% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Up to 30-day retail supply; 31-90-day mail/Maintenance Choice. You may be required to try generic drug(s) first to receive coverage. Limits apply to compound drugs. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Specialty drugs (Tier 4)	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	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.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>Copay</u> /visit, 20% <u>Coinsurance</u>	\$150 <u>Copay</u> /visit, 20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. Non- <u>network</u> emergency room services covered only for true medical emergencies.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	None
	<u>Urgent care</u>	20% <u>Coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	No non- <u>network</u> coverage. 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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	Not Covered	No non- <u>network</u> coverage. 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>Copay</u> /visit then 0% <u>Coinsurance</u>	Not Covered	No non- <u>network</u> coverage. 3 No Cost EAP in person visits
	Inpatient services	20% <u>Coinsurance</u>	Not Covered	No non- <u>network</u> coverage.
If you are pregnant	Office visits	\$20 <u>Copay</u> /initial visit only	Not Covered	Routine pre-natal care covered at no charge. No non- <u>network</u> coverage.
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	Not Covered	120 visit limit/calendar year.
	<u>Rehabilitation services</u>	\$30 <u>Copay</u> /visit	Not Covered	None
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	Not Covered	Limit of 120 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	20% <u>Coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	20% <u>Coinsurance</u>	Not Covered	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Adult routine vision exam (i.e. refraction) • Child dental check-up • Child vision glasses • Cosmetic Surgery 	<ul style="list-style-type: none"> • Dental Care (Adult) • <u>Habilitation services</u> • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Private-duty nursing • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • 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.lubrizon.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, kwijjigo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall deductible	\$750	■ The <u>plan's</u> overall deductible	\$750	■ The <u>plan's</u> overall deductible	\$750
■ <u>Specialist copayment</u>	\$30	■ <u>Specialist copayment</u>	\$30	■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic tests</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750	<u>Deductibles</u>	\$750	<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0	<u>Copayments</u>	\$220	<u>Copayments</u>	\$210
<u>Coinsurance</u>	\$1,500	<u>Coinsurance</u>	\$984	<u>Coinsurance</u>	\$276
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$2,310	The total Joe would pay is	\$2,009	The total Mia would pay is	\$1,236




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:
<p>What is the overall deductible?</p>	<p><u>Network</u>: \$750 Individual* / \$1,500 Individual Plus 1 / \$2,150 Family <u>Non-Network</u>: \$750 Individual* / \$1,500 Individual Plus 1 / \$2,150 Family per calendar year. Does not apply to <u>copayments</u>, and services listed below as "No Charge". *Does not apply if policy covers more than one person.</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. <u>Preventive Care</u> and categories with <u>copayments</u> are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific service, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Medical- <u>Network</u>: \$2,250 Individual* / \$4,500 Individual Plus 1 / \$6,750 <u>Non-Network</u>: \$2,250 Individual* / \$4,500 Individual Plus 1 / \$6,750 Family per calendar year *Does not apply if policy covers more than one person.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, the overall family <u>out-of-pocket limits</u> must be met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billing charges</u>, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.myuhc.com or call 1-877-706-1735 for a list of <u>network providers</u> in the UnitedHealthcare Options PPO Network.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Designated Virtual <u>Network Provider</u> covered at 20% <u>coinsurance</u> per visit (after deductible). No virtual visit coverage for non- <u>network</u> . If you receive services in addition to office visit, additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	<u>Specialist</u> visit	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	None.
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	Prior Authorization required Non- <u>Network</u> for Sleep Studies or \$500 penalty. COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	COE services include Bariatric Resources Services, Cancer Resource Services, Congenital Heart Disease, and Spine and Joint Solution.
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.caremark.com</u></p>	Generic Drugs (Tier 1)	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	Retail: 10% <u>Coinsurance</u> Mail Order: 10% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	Retail: 20% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	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% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Retail: 30% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Up to 30-day retail supply; 31-90-day mail/Maintenance Choice. You may be required to try generic drug(s) first to receive coverage. Limits apply to compound drugs. Certain pain patches are excluded. Opioid limitations described for Generic Drugs apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Specialty drugs (Tier 4)	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	Retail: Not Covered Mail Order: 35% <u>Coinsurance</u>	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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>Copay</u> /visit, 20% <u>Coinsurance</u>	\$150 <u>Copay</u> /visit, 20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
	<u>Urgent care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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% <u>Coinsurance</u> / 10% <u>Coinsurance</u> for Centers of Excellence Services	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	3 No Cost EAP in person visits.
	Inpatient services	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
If you are pregnant	Office visits	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Routine pre-natal care covered at no charge. Prior Authorization required for Non- <u>Network</u> inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or \$500 penalty.
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. 120 visit limit/calendar year.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> in-patient rehabilitation facility or \$500 penalty.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty. Limit of 120 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for DME devices that cost more than \$1,000 or \$500 penalty.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	Prior Authorization required for Non- <u>Network</u> or \$500 penalty.
If your child needs dental or eye care	Children's eye exam	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Adult routine vision exam (i.e. refraction) Child dental check-up Child vision glasses Cosmetic Surgery 	<ul style="list-style-type: none"> Dental Care (Adult) <u>Habilitation services</u> Infertility treatment Long-term care 	<ul style="list-style-type: none"> Private-duty nursing Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery 	<ul style="list-style-type: none"> Chiropractic care Hearing aids 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 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, kwijigo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall deductible	\$750	■ The <u>plan's</u> overall deductible	\$750	■ The <u>plan's</u> overall deductible	\$750
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750	<u>Deductibles</u>	\$750	<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500	<u>Coinsurance</u>	\$1,196	<u>Coinsurance</u>	\$385
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$55	Limits or exclusions	\$0
The total Peg would pay is	\$2,310	The total Joe would pay is	\$2,001	The total Mia would pay is	\$1,135