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 go to www.caremark.com. 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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	See Medical SBC	
Are there services covered before you meet your deductible?	See Medical SBC	
Are there other deductibles for specific services?	See Medical SBC	
What is the out-of-pocket limit for this plan?	For network pharmacy providers $2,100 individual / $4,200 family	
What is not included in the out-of-pocket limit?	See Medical SBC	
Will you pay less if you use a network provider?	See Medical SBC	
Do you need a referral to see a specialist?	See Medical SBC	

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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	See Medical SBC		
	Specialist visit	See Medical SBC		
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	See Medical SBC		
	Imaging (CT/PET scans, MRIs)	See Medical SBC		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs.com	Generic drugs	$10 copay		$20 copay for Mail order.
	Preferred brand drugs	$30 copay		$60 copay for Mail order.
	Non-preferred brand drugs	$50 copay		$100 copay for Mail order.
	Specialty drugs	Applicable tier copay applies		Applicable tier copay applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical SBC		
	Physician/surgeon fees	See Medical SBC		
If you need immediate medical attention	Emergency room care	See Medical SBC		
	Emergency medical transportation	See Medical SBC		
	Urgent care	See Medical SBC		
If you have a hospital stay	Facility fee (e.g., hospital room)	See Medical SBC		
	Physician/surgeon fees	See Medical SBC		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical SBC		
	Inpatient services	See Medical SBC		
If you are pregnant	Office visits	See Medical SBC		
	Childbirth/delivery professional services	See Medical SBC		

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)	
	Childbirth/delivery facility services	See Medical SBC		
If you need help recovering or have other special health needs	Home health care	See Medical SBC		
	Rehabilitation services	See Medical SBC		
	Habilitation services	See Medical SBC		
	Skilled nursing care	See Medical SBC		
	Durable medical equipment	See Medical SBC		
	Hospice services	See Medical SBC		
If your child needs dental or eye care	Children's eye exam	See Medical SBC		
	Children's glasses	See Medical SBC		
	Children's dental check-up	See Medical SBC		

Excluded 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.)

- Experimental Therapies
- Over the counter items
- Non-FDA approved indications

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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact www.caremark.com or 1-866-808-7159

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的**帮**助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

About these Coverage Examples:

*See Medical Summary of Benefits & Coverage (SBC)