




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](http://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 <a href="#">deductible</a> ?                                | See Medical SBC  |                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | See Medical SBC  |                   |
| Are there other <a href="#">deductibles</a> for specific services?              | See Medical SBC  |                   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For network pharmacy providers \$2,100 individual / \$4,200 family |                   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | See Medical SBC  |                   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | See Medical SBC  |                   |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | See Medical SBC  |                   |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | See Medical SBC                              |  |  |
|  | <a href="#">Specialist</a> visit                       | See Medical SBC                              |  |  |
|  | <a href="#">Preventive care/screening/immunization</a> |  |  |  |
| If you have a test   | <a href="#">Diagnostic test</a> (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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cvs.com">www.cvs.com</a> | 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.                            |
|  | <a href="#">Specialty drugs</a>                        | 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  | <a href="#">Emergency room care</a>                    | See Medical SBC                              |  |  |
|  | <a href="#">Emergency medical transportation</a>       | See Medical SBC                              |  |  |
|  | <a href="#">Urgent care</a>                            | 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                              |  |  |

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|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|  | Childbirth/delivery facility services     | See Medical SBC                              |  |  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | See Medical SBC                              |  |  |
|  | <a href="#">Rehabilitation services</a>   | See Medical SBC                              |  |  |
|  | <a href="#">Habilitation services</a>     | See Medical SBC                              |  |  |
|  | <a href="#">Skilled nursing care</a>      | See Medical SBC                              |  |  |
|  | <a href="#">Durable medical equipment</a> | See Medical SBC                              |  |  |
|  | <a href="#">Hospice services</a>          | 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](http://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](http://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](http://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](http://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, kwijigo holne' [insert telephone number].]

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

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About these Coverage Examples:



**\*See Medical Summary of Benefits & Coverage (SBC)**