This is only a summary. If you want more detail about your prescription coverage and costs, you can get the complete terms in the policy or plan document at www.ehimrx.com or by calling 1-800-311-3446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	See Medical Plan	There are no deductibles specific to the Prescription Plan. Refer to your medical SBC for information regarding your medical coverage.
Are there services covered before you meet your deductible?	See Medical Plan	See Medical Plan
Are there other deductibles for specific services?	See Medical Plan	See Medical Plan
What is the out-of-pocket limit for this plan?	$4,200 per single $8,400 per family	The most you pay in prescription copays during the Coverage Period before your Prescription Plan begins to pay 100% of the allowed amount is $4,200 per Single and $8,400 per Two-Person/Family. This out-of-pocket limit applies to all covered Essential Health Benefit (EHB) prescriptions that are a part of your Prescription Plan.
What is not included in the out-of-pocket limit?	Premium, Balance Billed Charges, Non-Covered Medications, Medications not on the EHB Drug List	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	See Medical Plan	For a list of participating pharmacies, see www.ehimrx.com or call 800-311-3446.
Do you need a referral to see a specialist?	See Medical Plan	See Medical Plan

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 Plan	See Medical Plan	See Medical Plan
	Specialist visit	See Medical Plan	See Medical Plan	See Medical Plan
	Preventive care/screening/ immunization	See Medical Plan	See Medical Plan	See Medical Plan
If you have a test	Diagnostic test (x-ray, blood work)	See Medical Plan	See Medical Plan	See Medical Plan
	Imaging (CT/PET scans, MRIs)	See Medical Plan	See Medical Plan	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 800-311-3446	Generic drugs (Tier 1)	$10 / per Rx	$10 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Preferred brand drugs (Tier 2)	$30 / per Rx	$30 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Non-preferred brand drugs (Tier 3)	$80 / per Rx	$80 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Specialty drugs (Tier 4)	50% / per Rx	50% / per Rx	Covers up to 30 day supply; Quantity Limitations on certain medications; prior authorization may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical Plan	See Medical Plan	See Medical Plan
	Physician/surgeon fees	See Medical Plan	See Medical Plan	See Medical Plan
	Emergency room care	See Medical Plan	See Medical Plan	See Medical Plan

[*For more information about limitations and exceptions, see your plan administrator]

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 need immediate medical attention	Emergency medical transportation	See Medical Plan	See Medical Plan	See Medical Plan
	Urgent care	See Medical Plan	See Medical Plan	See Medical Plan
If you have a hospital stay	Facility fee (e.g., hospital room)	See Medical Plan	See Medical Plan	See Medical Plan
	Physician/surgeon fees	See Medical Plan	See Medical Plan	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical Plan	See Medical Plan	See Medical Plan
	Inpatient services	See Medical Plan	See Medical Plan	See Medical Plan
If you are pregnant	Office visits	See Medical Plan	See Medical Plan	See Medical Plan
	Childbirth/delivery professional services	See Medical Plan	See Medical Plan	See Medical Plan
	Childbirth/delivery facility services	See Medical Plan	See Medical Plan	
If you need help recovering or have other special health needs	Home health care	See Medical Plan	See Medical Plan	See Medical Plan
	Rehabilitation services	See Medical Plan	See Medical Plan	
	Habilitation services	See Medical Plan	See Medical Plan	
	Skilled nursing care	See Medical Plan	See Medical Plan	
	Durable medical equipment	See Medical Plan	See Medical Plan	
	Hospice services	See Medical Plan	See Medical Plan	
If your child needs dental or eye care	Children's eye exam	See Medical Plan	See Medical Plan	See Medical Plan
	Children's glasses	See Medical Plan	See Medical Plan	See Medical Plan
	Children's dental check-up	See Medical Plan	See Medical Plan	See Medical Plan

[*For more information about limitations and exceptions, see your plan administrator]

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.)

- Cosmetic drug
- Dental fluorides
- Diabetic Supplies
- Experimental drugs
- Fertility drugs
- Growth hormones
- Injectable allergens/immunizations/blood/prod.
- Medical appliances/devices
- Injectable impotency agents
- Prescription vitamins

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

- Select Over the Counter Drugs for $10 copay per 30 day fill. Must present valid prescription.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

Language Access Services: Language Access Services

[*For more information about limitations and exceptions, see your plan administrator]