
 **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 \$3,700 per Single and \$7,400 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 |

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
- 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](#)