**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.optumrx.com** or by calling **1-800-356-3477**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **Not applicable** | This document only refers to your Rx coverage. |
| **Are there other deductibles for specific services?** | **No, does not apply to your Rx program** | You don't have to meet deductibles for specific services under the Rx program. |
| **Is there an out–of–pocket limit on my expenses?** | **No** | An out-of-pocket limit is the most you could pay during a calendar year period (January 1st – December 31st) for your share of the cost of covered drugs (e.g., deductible, copay). |
| **What is not included in the out–of–pocket limit?** | **N/A** | Not applicable to your Rx program |
| **Is there an overall annual limit on what the plan pays?** | **No, does not apply to your Rx program** | Not applicable to your Rx program. |
| **Does this plan use a network of providers?** | **Yes, please visit www.optumrx.com for a list of participating pharmacies** | If you use a non-participating pharmacy, you will be required to pay the pharmacy the full retail cost. You can be reimbursed only what we would have paid to a participating pharmacy less your copay by filling out a drug reimbursement claim form at www.optumrx.com. Please note you may be reimbursed less than what you actually paid at a non-participating pharmacy. |
| **Do I need a referral to see a specialist?** | **Not applicable to your Rx program** | |
| **Are there services this plan doesn't cover?** | **Yes** | Please refer to the brochure that was enclosed with your Rx ID card which describes what drugs are covered or not covered under your program. |

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not applicable | Not applicable | |
| | Specialist visit | Not applicable | Not applicable | |
| | Other practitioner office visit | Not applicable | Not applicable | |
| | Preventive care/screening/immunization | Not applicable | Not applicable | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not applicable | Not applicable | |
| | Imaging (CT/PET scans, MRIs) | Not applicable | Not applicable | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.benecardpbf.com. | Generic drugs | $10 retail copay<br>$25 mail order copay<br>$25 Retail 90 copay | 100% | 30 day supply retail<br>90 day supply mail order<br>Kroger Retail 90 Program |
| | Preferred brand drugs | $30 retail copay<br>$75 mail order copay<br>$75 Retail 90 copay | 100% | 30 day supply retail<br>90 day supply mail order<br>Kroger Retail 90 Program |
| | Non-preferred brand drugs | $60 retail copay<br>$150 mail order copay<br>$150 Retail 90 copay | 100% | 30 day supply retail<br>90 day supply mail order and<br>Kroger Retail 90 Program |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Specialty drugs | Injectable: $50<br>Non-Injectable: $10/$30/$60 for Tiers 1/2/3 | 100% | Up to a 30 day supply |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not applicable | Not applicable | |
| | Physician/surgeon fees | Not applicable | Not applicable | |
| **If you need immediate medical attention** | Emergency room services | Not applicable | Not applicable | |
| | Emergency medical transportation | Not applicable | Not applicable | |
| | Urgent care | Not applicable | Not applicable | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not applicable | Not applicable | |
| | Physician/surgeon fee | Not applicable | Not applicable | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Not applicable | Not applicable | |
| | Mental/Behavioral health inpatient services | Not applicable | Not applicable | |
| | Substance use disorder outpatient services | Not applicable | Not applicable | |
| | Substance use disorder inpatient services | Not applicable | Not applicable | |
| **If you are pregnant** | Prenatal and postnatal care | Not applicable | Not applicable | |
| | Delivery and all inpatient services | Not applicable | Not applicable | |
| **If you need help recovering or have other special health needs** | Home health care | Not applicable | Not applicable | |
| | Rehabilitation services | Not applicable | Not applicable | |
| | Habilitation services | Not applicable | Not applicable | |
| | Skilled nursing care | Not applicable | Not applicable | |
| | Durable medical equipment | Not applicable | Not applicable | |
| | Hospice service | Not applicable | Not applicable | |
| **If your child needs dental or eye care** | Eye exam | Not applicable | Not applicable | |
| | Glasses | Not applicable | Not applicable | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Dental check-up | Not applicable | Not applicable | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acne Products
- Alternative Medications
- Anti-fungals - Topical
- Anti-Obesity Agents
- Bacterial Vaccines
- Blood Pressure Devices
- Contraceptives
- Diabetic Supplies
- Dietary Management Products
- Fertility Regulators
- Hair Growth Agents
- Impotence Agents
- Infertility Treatments
- Multivitamins
- Nutritional Supplements
- Oral Hygiene Products
- Parenteral Therapy Supplies
- Prenatal Vitamins
- Smoking Deterrents

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 740-397-7422. You may also contact your state insurance department, 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.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact OptumRx at 1-800-356-3477.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." This Summary of Benefits and Coverage only applies to your prescription drug program. This prescription drug program alone, does not qualify as minimum essential coverage. However, to determine if your health coverage qualifies as minimum essential coverage, please contact the health plan at 1.800.887.6055.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This Summary of Benefits and Coverage only applies to your prescription drug program. This prescription drug program does meet the minimum value standard, please contact the health plan at 1.800.887.6055.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-356-3477.

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

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $10
- **Patient pays** $7,530

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $20 |
| Coinsurance | $0 |
| Limits or exclusions | $7,510 |
| **Total** | **$7,530** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,000
- **Patient pays** $3,400

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $700 |
| Coinsurance | $0 |
| Limits or exclusions | $1,300 |
| **Total** | **$2,000** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.