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, request the plan or policy document by calling 1-833-961-3021. 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 www.healthcare.gov/sbc-glossary or call 1-866-345-5189 or 1-562-463-5075 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | There is no deductible. | You do not have to meet a deductible. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | *Medical out-of-pocket limit:* $1,500 individual/$3,000 family<br><br>*Prescription drug out-of-pocket limit: (applicable to prescription drugs from network pharmacies, except certain specialty drugs):* $750 individual / $1,500/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | *Medical out-of-pocket limit:* Premiums, prescription drug costs, balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.<br><br>*Prescription drug out-of-pocket limit:* premiums, amounts (other than copayment) paid for brand drug when generic is available, balance-billing charges, and health care this plan doesn't cover. Copayments for certain specialty drugs that are not essential health benefits (though eligible for reimbursement by the manufacturer at no cost to you) do not apply towards satisfying your out-of-pocket limit and will not be reimbursed at 100% once the out-of-pocket limit is reached. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. Call 1-833-961-3021 or go to www.mlkchplan.com for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 | $5 copay/visit | Not covered | None. |
| | Specialist visit | $5 copay/visit | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | |

* For more information about limitations and exceptions, please request the plan or policy document by calling 1-833-961-3021.

| 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 drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.express-scripts.com or call 1-800-451-6245. | Preventive drugs | No charge | Not covered | You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. Some drugs require preauthorization.<br>Each retail prescription limited to a maximum 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order. For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision.<br>If you use a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay. No charge for ACA-required preventive care drugs if purchased at a network pharmacy with a prescription from a physician.<br>For information on drugs not covered by the plan, call 1-800-451-6245, visit www.express-scripts.com, or download the Express Scripts app. |
| | Generic drugs | $3 copay / prescription (retail or mail order) | Not covered | |
| | Brand name drugs | $ 6 copay / prescription (retail)<br>$5 copay / prescription (mail order) | Not covered | |
| | Specialty drugs | $3 copay for generic (retail or mail order)<br>$ 6 copay / brand prescription (retail)<br>$5 copay / brand prescription (mail order) | Not covered | Except in case of urgent medical need, specialty medications must be filled through the Accredo pharmacy.<br>Certain specialty drugs have substantially higher copays than shown. If you are on one of these specialty drugs and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher copays. However, if your specialty drug is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full copay. The specialty drugs on the SaveOn SP Drug list, and the copays for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a specialty drug that is part of the SaveOn SP program. |

| 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| | Physician/surgeon fees | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| If you need immediate medical attention | Emergency room care | $150 copay/visit | $150 copay/visit | Copay waived if admitted as inpatient. Emergency medical transportation covered only when medically necessary. No balance billing for Out-of-Network coverage of Emergency Services |
| | Emergency medical transportation | $50/transport | $50/transport | |
| | Urgent care | $10 copay/visit | Not covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | All hospitalizations, except Emergency and childbirth, require referral from your primary care provider and prior authorization or no coverage.<br>Maximum benefit for hospitalization is $100,000 per hospitalization. (Not applicable to Emergency Services). |
| | Physician/surgeon fees | No charge | Not covered | ——————none—————— |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office-$5 copay/visit Other than office- No charge | Not covered | None |
| | Inpatient services | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| If you are pregnant | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization required if hospital stay more than 48 hours (vaginal delivery) or 96 hours (C-section). |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | No charge | Not covered | |

| 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 help recovering or have other special health needs | Home health care | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. Homemaker services not covered. |
| | Rehabilitation services | $5 copay/visit | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| | Habilitation services | $5 copay/visit | Not covered | |
| | Skilled nursing care | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. Limited to 100 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | Not covered | Corrective footwear is not covered. Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| | Hospice services | No charge | Not covered | Requires referral from your primary care provider and prior authorization, otherwise not covered. |
| If your child needs dental or eye care | Children's eye exam | *MLK Program*: Not covered<br>*VSP*: No charge. | All costs above $45 allowance. | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Eye exams limited to one exam every 12 months. |
| | Children's glasses | *MLK Program*: Not covered<br>*VSP*: 80% of costs above $120 allowance for basic frames. No charge for most standard lenses. | *MLK Program*: Not covered<br>*VSP:* Frames: All costs above $70 allowance. Lenses: All costs above $30 (single vision lenses), $50 (bifocals & standard progressives), $65 (trifocals). | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months.<br>Charges apply for lens add-ons and premium progressive lenses. |
| | Children's dental check-up | Not covered | Not covered | You may have other dental coverage not described here. |

* For more information about limitations and exceptions, please request the plan or policy document by calling 1-833-961-3021.

## 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 surgery
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (Requires referral from your primary care provider and prior authorization, otherwise not covered)
- Bariatric surgery (Requires referral from your primary care provider and prior authorization, otherwise not covered)
- Chiropractic care (Requires referral from your primary care provider and prior authorization, otherwise not covered)
- Dental care (Adult) - (available through separate standalone plan)
- Routine eye care (Adult) – (eye exams and materials available through VSP plan).

**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 the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: Design Benefit Administrators, the Fund's Claims Administrator at 1-833-961-3021. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 1-833-961-3021.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-961-3021.

[Chinese (**中文**): **如果需要中文的帮助**, 请拨打这个号码 1-833-961-3021.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-961-3021.

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

* For more information about limitations and exceptions, please request the plan or policy document by calling 1-833-961-3021.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $5 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | 20% |

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| Total Example Cost | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $70 |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $5 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | 20% |

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $220 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $5 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | 20% |

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $350 |

The plan would be responsible for the other costs of these EXAMPLE covered services.