



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 ?	<i>Medical out-of-pocket limit: \$1,500 individual/\$3,000 family Prescription drug out-of-pocket limit: (applicable to prescription drugs from <u>network pharmacies</u>, except certain <u>specialty drugs</u>): \$750 individual / \$1,500/family</i>	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 ?	<i>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 3. 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 <u>specialty drugs</u> 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.</i>	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 ?	Yes. Call 1-833-961-3021 or go to www.mlkchplan.com for a list of <u>network providers</u> .	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

Important Questions	Answers	Why This Matters:
		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	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-800-451-6245.	Generic drugs	\$3 copay / prescription (retail or mail order)	Not covered	You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. 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. Except in case of urgent medical need, specialty medications must be filled
	Brand name drugs	\$ 6 copay / prescription (retail) \$5 copay / prescription (mail order)	Not covered	
	Specialty drugs	\$3 copay for generic (retail or mail order) \$ 6 copay / brand prescription (retail)	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)	
		\$5 copay / brand prescription (mail order)		<p>through the Accredo pharmacy.</p> <p>Some drugs require <u>preauthorization</u>. 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 <u>preventive care</u> drugs if purchased at a <u>network</u> pharmacy with a prescription from a physician.</p> <p>For information on drugs not covered by the <u>plan</u>, call 1-800-451-6245, visit www.express-scripts.com, or download the Express Scripts app.</p> <p>Certain <u>specialty drugs</u> have substantially higher <u>copays than shown</u>. If you are on one of these <u>specialty drugs</u> and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher copays. However, if your <u>specialty drug</u> is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full <u>copay</u>. The <u>specialty drugs</u> on the SaveOn SP Drug list, and the <u>copays</u> for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a <u>specialty drug</u> that is part of the SaveOn SP program. Please see "Important Questions" on page 1 for more information regarding the <u>prescription drug</u> out-of-pocket limit.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
	Physician/surgeon fees	No charge	Not covered	Requires <u>referral</u> from your <u>primary care</u>

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<u>provider</u> and prior authorization, otherwise not covered.
If you need immediate medical attention	Emergency room care	\$150 copay /visit	\$150 copay /visit	<u>Copay</u> waived if admitted as inpatient. <u>Emergency medical transportation</u> covered only when <u>medically necessary</u> . Out-of-network coverage subject to <u>balance billing</u> .
	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 <u>hospitalizations</u> , except Emergency and childbirth, require <u>referral</u> from your <u>primary care provider</u> and prior authorization or no coverage. Maximum benefit for <u>hospitalization</u> is \$100,000 per <u>hospitalization</u> .
	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 <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Preauthorization</u> 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	

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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 <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered. Homemaker services not covered.
	Rehabilitation services	\$5 <u>copay</u> /visit	Not covered	Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
	Habilitation services	\$5 <u>copay</u> /visit	Not covered	Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
	Skilled nursing care	No charge	Not covered	Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered. Limited to 100 days per calendar year.
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Corrective footwear is not covered. Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
	Hospice services	No charge	Not covered	Requires <u>referral</u> from your <u>primary care provider</u> and prior authorization, otherwise not covered.
If your child needs dental or eye care	Children's eye exam	MLK Program: Not covered 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. (Eye exams may be obtained through the MLK Program with a \$5 copay until October 31, 2021).
	Children's glasses	MLK Program: Not covered VSP: 80% of costs above \$120 allowance for basic frames. No charge for most standard lenses.	MLK Program: Not covered VSP: Frames: All costs above \$70 allowance. Lenses: All costs above \$30 (single vision lenses), \$50 (bifocals and standard progressives), and \$65 (trifocals) allowances.	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. 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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-961-3021.

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:



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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0

<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0

<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$50

<i>What isn't covered</i>	
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.