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, call ARORx at 833.306.4092. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 833.306.4092 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Not Applicable.	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?	Not Applicable.	There are no deductibles specific to the Prescription Plan. Refer to your medical SBC for information regarding your medical coverage.
Are there other deductibles for specific services?	Not Applicable.	There are no deductibles specific to the Prescription Plan. Refer to your medical SBC for information regarding your medical coverage.
What is the out-of-pocket limit for this plan?	For network providers $1,350 individual/$2,700 family. For non-network providers $2,700 individual/$5,400 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. The out-of-pocket limit is combined between the prescription plan and the medical plan. See medical plan SBC.
What is not included in the out-of-pocket limit?	Premium, Balance Billed Charges, Non-Covered Medications	This limit does not include your premium, balance billed charges, or prescription coverage that your prescription plan does not cover including out of network payments.
Will you pay less if you use a network provider?	Yes.	For a list of participating pharmacies, see www.members.arorx.com or call 833.306.4092.
Do you need a referral to see a specialist?	Not Applicable.	Refer to your medical SBC for information regarding your medical coverage.

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 SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Specialist visit	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Preventive care/screening/ immunization	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you have a test	Diagnostic test (x-ray, blood work)	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Imaging (CT/PET scans, MRIs)	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$10 copay/prescription (up to 31-day supply) $20 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition.	Deductible does not apply to copays. Covers up to a 31-day supply (retail prescription); 32-90 day supply (mail order or retail prescription). ACA mandated preventive drugs such as select contraceptive and tobacco cessation medications are covered with no member cost share. Preferred Tobacco Cessation Products are not available in 32 to 90-day supplies. Some drugs require prior approval for coverage. Call ARORx for more information.
	Preferred brand drugs	$40 copay/prescription (up to 31-day supply) $80 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition.	
	Non-preferred brand drugs	$80 copay/prescription (up to 31-day supply) $160 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition.	
	Specialty drugs	Contact ARORx.	Not covered.	Contact ARORx at askthepharmacist@arorx.com or call 833.306.4092.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Physician/surgeon fees	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you need immediate medical attention	Emergency room care	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Emergency medical transportation	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.

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)	
	Urgent care	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Physician/surgeon fees	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Inpatient services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you are pregnant	Office visits	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Childbirth/delivery professional services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Childbirth/delivery facility services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If you need help recovering or have other special health needs	Home health care	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Rehabilitation services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Habilitation services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Skilled nursing care	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Durable medical equipment	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Hospice services	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
If your child needs dental or eye care	Children's eye exam	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Children's glasses	See Medical SBC.	See Medical SBC.	This service is not part of your prescription plan.
	Children's dental check-up	See Medical SBC.	See Medical SBC.	This service is not part of your prescription 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.)
Contact ARORx at askthepharmacist@arorx.com or 833.306.4092.

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, 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 . 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: ARORx at 833.306.4092.

Does this plan provide Minimum Essential Coverage? See Medical SBC.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? See Medical SBC.
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 833.306.4092.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833.306.4092.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833.306.4092.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833.306.4092.]

[* For more information about limitations and exceptions, see the plan or policy document at www.members.arorx.com or call 833.306.4092.]