UMR: CONE HEALTH: 7670-00-430121 002, 003

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, visit www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person / **$3,000** family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
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?	**$4,000** person / **$8,000** family **$4,000** Maximum that any one person will satisfy toward the annual family out-of-pocket	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?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	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. See www.umr.com or call 1-800-826-9781 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?	No.	You can see the specialist you choose without a referral.

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
		Tier 1 (THN)	Tier 2 (Cone Health)	Tier 3 (UHC)	Tier 4 (Out-of-network)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 Copay per visit	$5 Copay per visit	40% Coinsurance	Not covered	None
	Specialist visit	20% Coinsurance	20% Coinsurance	40% Coinsurance	Not covered	None
	Preventive care/ screening/ immunization	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge when billed with an office visit; 40% Coinsurance when not billed with an office visit office setting; 20% Coinsurance labs; Not available x-rays outpatient setting	No charge when billed with an office visit; 20% Coinsurance when not billed with an office visit office setting & outpatient setting	40% Coinsurance office setting; 20% Coinsurance labs; 40% Coinsurance x-rays outpatient setting	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge when billed with an office visit; 40% Coinsurance when not billed with an office visit office setting; Not available outpatient setting	No charge when billed with an office visit; 20% Coinsurance when not billed with an office visit office setting & outpatient setting	40% Coinsurance	Not covered	None

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If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.medimpact.com/members.	Generic drugs (Tier 1)	Not covered	Cone Health Outpatient Pharmacies: Preferred - $5 Copayment. Non-Preferred - 20% coinsurance with minimum of $15	Retail Preferred: Preferred - $20 copayment. Non-Preferred - 30% coinsurance with a minimum of $25	Not covered	The overall plan deductible of $1,400 individual / $2,800 family must be met before copayment & coinsurance apply. Covers up to a 30-day supply for retail prescriptions and Cone Health Outpatient Pharmacies. 60 and 90-day supply also available at Cone Health Outpatient Pharmacies for additional copayment and minimum amounts. Specialty drugs limited to Cone Health Outpatient Pharmacies only. Cost sharing does not apply to certain generics and preventive care prescription drugs at the Cone Health Outpatient Pharmacies. After one 30-day retail pharmacy fill, maintenance drugs are covered only if purchased from the Cone Health Outpatient
	Preferred brand drugs (Tier 2)	Not covered	Cone Health Outpatient Pharmacies: 20% coinsurance with minimum of $30 and $125 maximum	Retail: 30% coinsurance with minimum of $50 and $150 maximum	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Cone Health Outpatient Pharmacies: 20% coinsurance with minimum of $100;	Retail: 50% coinsurance with minimum of $150 and $350 maximum	Not covered	

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	Specialty drugs (Tier 4)	Not covered	Cone Health Outpatient Pharmacies Only: Generic 20% coinsurance with $15 minimum and $250 maximum; Brand $250 copayment limited to a 30 day refill	Not covered	Not covered	Pharmacies. If you or your physician chooses a Preferred brand drug when a generic substitute is available, a prior authorization will be required. Coverage for certain drugs is subject to preauthorization, step therapy requirements, and/or quantity, dose or duration limits. To confirm whether this applies to a specific drug, contact MedImpact by calling (844) 401-2055. Certain specialty drugs, such as infused or physician-administered drugs, may be covered under the medical portion of the plan – see medical coverage section of this summary for cost information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance Ambulatory Surgery; Not available at all other facilities	20% Coinsurance	40% Coinsurance	Not covered	None
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	20% Coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	Not available	20% Coinsurance	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	Not available	No charge ground True ER; 20% Coinsurance ground Non-true ER; Not available air	No charge ground True ER; 20% Coinsurance ground Non-true ER & air	Not covered ground; 20% Coinsurance air	$25,000 Maximum benefit per occurrence air ambulance
	Urgent care	Not available	20% Coinsurance	20% Coinsurance	Not covered	None

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		Tier 1 (THN)	Tier 2 (Cone Health)	Tier 3 (UHC)	Tier 4 (Out-of-network)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	20% Coinsurance	40% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service for Tier 2 & 3.
	Physician/surgeon fee	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$5 Copay per office visit; 20% Coinsurance other outpatient services	$5 Copay per office visit; 20% Coinsurance other outpatient services	40% Coinsurance	40% Coinsurance office setting; Not covered other outpatient services	Preauthorization is required for Tier 2 & 3 Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	Not available	20% Coinsurance	20% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service for Tier 2 & 3.
If you are pregnant	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance	
	Childbirth/delivery facility services	Not available	20% Coinsurance	40% Coinsurance	Not covered	

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If you need help recovering or have other special health needs	Home health care	Not available	20% Coinsurance	20% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service for Tier 2 & 3.
	Rehabilitation services	40% Coinsurance office therapy; Not available hospital therapy	20% Coinsurance	40% Coinsurance	Not covered	None
	Habilitation services	Covered based on place of service	Covered based on place of service	Covered based on place of service	Not covered	None
	Skilled nursing care	Not available	20% Coinsurance	40% Coinsurance	Not covered	120 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service for Tier 2 & 3.
	Durable medical equipment	Not available	20% Coinsurance	20% Coinsurance	Not covered	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence for Tier 2 & 3.
	Hospice service	No charge	No charge	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	None
	Children's glasses	Not available	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not available	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (Tiers 1 & 3)
- Bariatric surgery (Tier 2 only)
- Chiropractic care (Tiers 1, 2 & 3)
- Hearing aids (Tiers 1, 2 & 3)
- Infertility treatment (Tiers 2 & 3)
- Routine eye care (Adult) (Tiers 1, 2 & 3)
- Routine foot care (Tiers 1, 2 & 3)

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? 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.