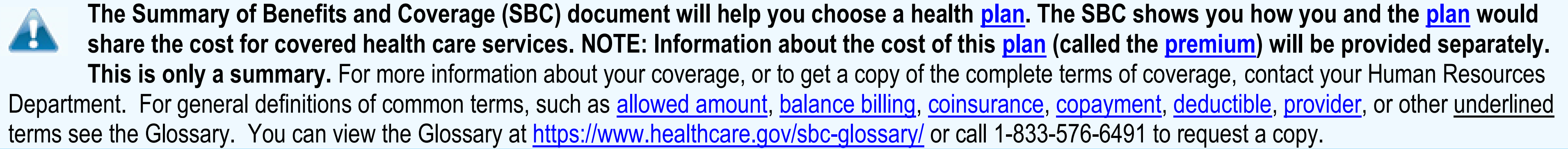
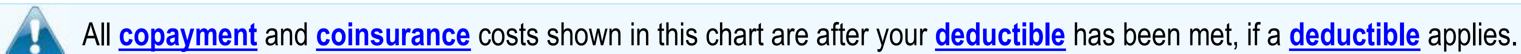


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your Human Resources Department. 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.healthcare.gov/sbc-glossary/ or call 1-833-576-6491 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Coordinated: **no deductible** Person/**no deductible** Family Uncoordinated: **$500** Person/**$1,000** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and your selected primary care physician 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. Services received under the coordinated care benefit are not subject to a deductible. 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?	Yes. Deductibles apply for services that have a coinsurance for uncoordinated care.	When a coinsurance applies, your deductible will apply prior to the coinsurance calculation. For example DME services.
What is the out-of-pocket limit for this plan?	Coordinated: **$2,500** Person/**$5,000** Family Uncoordinated: **$7,900** Person/**$15,800** 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. Your out-of-pocket limit will never exceed $7,900/person or $15,800/family.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain preauthorization, ineligible 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 http://conehealth.centivo.com or call 1-833-576-6491 to determine if a provider is in the network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. Your designated network primary care provider will direct all of your care through the provider network. This is considered coordinated care. If your Primary Care Provider is not involved in directing your care, the services are considered uncoordinated. You will pay the most if you use an out-of-network provider.
Do you need a referral to see a specialist?	Yes, for Coordinated benefits except for Network OB\GYN's.	This plan will pay a higher benefits level to see a specialist for covered services if you have a referral before you see the specialist.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Coordinated (You will pay the least)	Uncoordinated	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Your designated Primary Care Physician	$0 copay/office visit	40% coinsurance	Not Applicable	Copay or coinsurance includes all diagnostic tests billed with the Office Visit. Diagnostic testing billed without an Office Visit will be subject to the benefits listed below. E-visits through MyChart and MD Live Video Visits are covered at no charge. Please see your Summary Plan Description for full details.
	Specialist visits	$40 copay/visit	40% coinsurance	Not Covered	
	A visit with other (not designated) Primary Care Physician (not in the practice of the designated primary care physician)	$40 copay/visit	40% coinsurance	Not Covered	
	Preventive care/screening/ immunization	Covered at 100%	Covered at 100%	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, ultrasound, blood work)	$40 copay/test	40% coinsurance	Not Covered	
	Advanced Imaging (CT/PET scans, MRIs)	$150 copay/test	40% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Tier 1 (Cone Health)	Tier 2 (In-Nework)	Tier 3 (Out-of-Network)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs Preferred (Tier 1)	**Cone Health Outpatient Pharmacies:** Preferred Generics $5 copayment	**Retail Pharmacies:** Preferred Generics $20 copayment	Not covered	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 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.
	Generic Drugs Non-Preferred (Tier 1)	**Cone Health Outpatient Pharmacies:** Non-Preferred Generics 20% coinsurance with minimum of $15 No maximum limit	**Retail Pharmacies:** Non-Preferred Generics 30% coinsurance with a minimum of $25 No maximum limit		
	Preferred brand drugs (Tier 2)	**Cone Health Outpatient Pharmacies:** 20% coinsurance with minimum of $30 and $125 maximum	**Retail Pharmacies:** 30% coinsurance with minimum of $50 and $150 maximum	Not covered	
	Non-preferred brand drugs (Tier 3)	**Cone Health Outpatient Pharmacies:** 20% coinsurance with minimum of $100 No maximum limit	**Retail Pharmacies:** 50% coinsurance with minimum of $150 and $350 maximum	Not covered	
	Specialty drugs (Tier 4)	**Cone Health Outpatient Pharmacies:** Variable Copay – Copay varies in cost based on participation in Specialty Clinic benefit and available manufacturer copay cards that can be applied at the pharmacy to offset out-of-pocket-costs Limited to 30 day supply	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Coordinated (You will pay the least)	Uncoordinated	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay	40% coinsurance	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits could be payable at 60%coinsurance of the total cost of the service or denied in whole.
	Physician/surgeon fees	No charge	40% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	$500 copay/visit	Emergency room copay waived if admitted. Non emergent use of Emergency Room or Emergency Medical Transportation will result in additional copays and coinsurance.
	Emergency medical transportation	No charge	No charge	No charge	
	Urgent care	$75 copay/visit	20% coinsurance	Not Covered	
	Virtual Care	No charge	$40 copay/visit	Not Covered	Cone Health Video Visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay	40% coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	No Charge	40% coinsurance	Not Covered	Preauthorization is required for all inpatient stays at Network Provider.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Psychiatrist office visit: $50 copay/office visit Mental health outpatient counseling: No charge	Psychiatrist office visit: $50 copay/office visit Mental health outpatient counseling: No charge	Psychiatrist office visit: $50 copay/office visit Mental health outpatient counseling: No charge	You do not need a referral for outpatient services.
	Inpatient services	$750 copay/visit	$750 copay/visit	Not Covered	Preauthorization is required for all inpatient stays. Residential inpatient program are only covered for acute days as determined by MedWatch.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Coordinated (You will pay the least)	Uncoordinated	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$600 copay	40% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Your provider's (OBGYN) office may charge your office visit copay upfront totaling $450.
	Childbirth/delivery professional services	No charge	40% coinsurance	Not Covered	
	Childbirth/delivery facility services	$750 copay	40% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	$40 copay/visit	40% coinsurance	Not Covered	
	Habilitation services	$40 copay/visit	40% coinsurance	Not Covered	
	Skilled nursing care	20% coinsurance	40% coinsurance	Not Covered	120 DAYS/calendar year Preauthorization is required
	Durable medical equipment	20% coinsurance	40% coinsurance	Not Covered	Durable Medical Equipment over $500 requires preauthorization. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	No charge	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	No Charge	Not Covered	Coverage limited to one exam/year.
	Children's glasses	Not covered			
	Children's dental check-up	Not covered			

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.)		
• Biofeedback • Cosmetic Surgery • Dental Care	• Long Term Care • Non-emergency care when traveling outside the U.S.	• Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes and limited to $500 Calendar Year maximum) • Bariatric Surgery – Please see the Summary Plan Description for further details on covered services and utilization review.	• Chiropractic Care – limited to 12 manipulations per Calendar Year and subject to $500 Calendar Year maximum • Routine eye care (Adult)	• Holistic, Homeopathic, and other alternative treatments subject to $500 Calendar Year maximum • Infertility Treatment • Nutritional Therapy/Dietary Counseling

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: Consociate – 1-800-798-2422. 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/healthreform or the U.S. Department of Health and Human Services at 1-877-267-232 x 61565 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: Consociate – 1-800-798-2422. You can also contact the 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.
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 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. Contact Consociate, and you will be referred to a translator, if available:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-798-2422.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422.