
 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 Quantum Health at 1-833-740-3260. 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 1-800-877-1122 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall <u>deductible</u>?	Per participant:	Network \$1,600	Non-Network \$4,800
	Per family:	\$3,200	\$9,600
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Network preventive care</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Per participant:	Network \$3,200	Non-Network \$9,600
	Per family:	\$6,400	\$19,200
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum <u>allowed amounts</u> , penalties, and non-medically necessary services.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.concordiaplans.quantum-health.com/ or call 1-833-740-3260 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	<u>Specialist</u> visit	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No Charge, deductible waived	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required for MRI/MRA and PET scans.

* For more information about limitations and exceptions, call 1-833-740-3260 or see the plan or policy document at [ConcordiaPlans.Quantum-Health.com](https://www.concordiaplans.quantum-health.com).

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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)	Non-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available by calling 1-833-740-3260.</p>	Generic drugs	<p>Thirty (30) Day Supply: \$10 copayment after deductible</p> <p>Thirty-One (31) to Ninety (90) Day Supply: \$25 copayment after deductible</p>	<p>Covered at the network pharmacy cost share plus any amounts over the network allowed amount.</p>	<p>Covers up to a thirty (30) day supply (retail prescription), or a thirty-one (31) to ninety (90) day supply (through Express Scripts mail order pharmacy or Walgreens only).</p> <p>Generic preventive drugs and generic diabetic supplies are covered at no charge, <u>deductible</u> waived.</p> <p>Dispense as Written (DAW), step therapy, and prior authorization requirements may apply.</p> <p>Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u>, log into your account at www.express-scripts.com.</p> <p>If you obtain <u>prescription drugs</u> from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement.</p> <p>Preferred Brand Insulin and Diabetic Drugs:</p> <p>Thirty (30) Day Supply: \$25 <u>copayment</u>, <u>deductible</u> waived</p> <p>Sixty (60) Day Supply: \$50 <u>copayment</u>, <u>deductible</u> waived</p> <p>Ninety (90) Day Supply: \$75 <u>copayment</u>, <u>deductible</u> waived</p>
	Preferred brand drugs	<p>Thirty (30) Day Supply: 30% coinsurance after deductible (\$25 minimum, \$75 maximum per prescription)</p> <p>Thirty-One (31) to Ninety (90) Day Supply: 30% coinsurance after deductible (\$62.50 minimum, \$187.50 maximum per prescription)</p>		
	Non-preferred brand drugs	<p>Thirty (30) Day Supply: 40% coinsurance after deductible (\$50 minimum, \$100 maximum per prescription)</p> <p>Thirty-One (31) to Ninety (90) Day Supply: 40% coinsurance after deductible (\$125 minimum, \$250 maximum per prescription)</p>		
	<u>Specialty drugs</u>	Applicable benefit as shown above		

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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)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance after network deductible		_____none_____
	<u>Emergency medical transportation</u>	20% coinsurance after network deductible		_____none_____
	<u>Urgent care</u>	20% coinsurance after network deductible		_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required for partial hospitalization and intensive outpatient programs. Includes eight (8) annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.

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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)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Prenatal Care: No Charge deductible waived* Postpartum Care: 20% coinsurance after deductible	Prenatal Care: Not Covered Postpartum Care: 40% coinsurance after deductible	*Labs and x-rays rendered at a routine prenatal care office visit will fall to the lab/x-ray benefit. Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special needs	<u>Home health care</u>	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.
	<u>Rehabilitation services</u>	20% coinsurance after deductible	40% coinsurance after deductible	Medical necessity will be reviewed after twenty (20) visits.
	<u>Habilitation services</u>	20% coinsurance after deductible	40% coinsurance after deductible	Medical necessity will be reviewed after twenty (20) visits.
	<u>Skilled nursing care</u>	20% coinsurance after deductible	40% coinsurance after deductible	Calendar Year Limit: One hundred (100) days per plan participant. Pre-certification is required.
	<u>Durable medical equipment</u>	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required for all rentals and any purchase over \$1,500.
	<u>Hospice services</u>	20% coinsurance after deductible	40% coinsurance after deductible	Respite care is limited to five (5) consecutive days at a time. Pre-certification is required.

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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)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered		_____none_____
	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.)

- Abortion (unless medically necessary)
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long-Term Care
- Routine Eye Care
- 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 (Limited to treatment for chronic pain and prevention or treatment of nausea associated with surgery, chemotherapy, or pregnancy)
- Bariatric Surgery
- Chiropractic Care [Limited to twenty-six (26) visits per calendar year]
- Hearing Aids [Limited to \$2,000 every three (3) years for children up to age eighteen (18)]
No limit for children up to twelve (12) months old.
- Non-Emergency Care When Traveling Outside the U.S (Limited to Global Core providers)
- Private-Duty Nursing

* For more information about limitations and exceptions, call 1-833-740-3260 or see the plan or policy document at ConcordiaPlans.Quantum-Health.com.

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may also contact the Plan Administrator at 1-888-927-7526 or info@ConcordiaPlans.org. 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. You may also contact the Care Coordinators to assist the plan administrator. The Care Coordinators' name, address, and telephone number are:

Quantum Health Care Coordinators
Attention: Appeals
5240 Blazer Parkway
Dublin OH 43017
1-833-740-3260

Additionally, a consumer assistance program can help you file your appeal. For information regarding your own state's consumer assistance program, refer to <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 1-833-740-3260.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-740-3260.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-740-3260.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-740-3260.

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 <u>plan's overall deductible</u>	\$1,600
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$0
Coinsurance	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,260

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$1,600
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$1,600
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other cost sharing</u>	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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$10
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,810

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