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 deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. 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.
	Per participant:	$1,800	$3,600	
	Per family:	$3,600	$7,200	
Are there services covered before you meet your deductible?	Yes. Network preventive care and services with a copayment.			This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply.
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?		**Network**	**Non-Network**	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.
	Per participant:	$5,400 + applicable copayments	$14,400 + applicable copayments	
	Per family:	$10,800 + applicable copayments	$28,800 + applicable copayments	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, penalties, non-medically necessary services, medical copayments, and prescription drugs.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See ConcordiaPlans.quantum-health.com or call 1-833-740-3260 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
		Network Provider (You will pay the least)	Non-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	No Charge after deductible	No Charge after deductible	——————none——————
	Specialist visit	No Charge after deductible	No Charge after deductible	
	Preventive care/screening/ immunization	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)	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.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-833-740-3260.	Generic drugs	**Thirty (30) Day Supply:** $15 copayment **Thirty-One (31) to Ninety (90) Day Supply:** $25 copayment	Covered at the network pharmacy cost share plus any amounts over the network allowed amount.	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). Prescription drugs do not apply to the deductible or out-of-pocket maximum. Dispense as Written (DAW), step therapy, and prior authorization requirements may apply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.express-scripts.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. Certain specialty medications are eligible for the SaveOnSP program. Members who are taking eligible SaveOnSP medications will be requested to enroll in the program. If a member chooses not to participate in SaveOnSP, they will pay a higher cost share.
	Preferred brand drugs	**Thirty (30) Day Supply:** $30 copayment **Thirty-One (31) to Ninety (90) Day Supply:** $60 copayment		
	Non-preferred brand drugs	**Thirty (30) Day Supply:** $60 copayment **Thirty-One (31) to Ninety (90) Day Supply:** $120 copayment		
	Specialty drugs	Applicable benefit as shown above		
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	

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

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 need immediate medical attention	Emergency room care	$120 copayment, deductible waived		Copayment waived if admitted within twenty-four (24) hours.
	Emergency medical transportation	20% coinsurance after network deductible		——————————none——————————
	Urgent care	$35 copayment, deductible waived	40% coinsurance after deductible	Urgent care copayment includes all services rendered during an urgent care visit. Non-network services apply to the network deductible and out-of-pocket limit.
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	No Charge, deductible waived		**Pre-certification is required for partial hospitalization and intensive outpatient programs.** Includes six (6) annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	No Charge, deductible waived		**Pre-certification is required.**
If you are pregnant	Office visits	No Charge after deductible	No Charge after deductible	Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	No Charge after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	

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

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 need help recovering or have other special needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	**Pre-certification is required.**
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Medical necessity will be reviewed after twenty (20) visits.
	Habilitation services	Applicable benefit as billed	Applicable benefit as billed	Medical necessity will be reviewed after twenty (20) visits.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	**Calendar Year Limit:** One hundred (100) days per plan participant. **Pre-certification is required.**
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	**Pre-certification is required for all rentals and any purchase over $1,500.**
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Respite care is limited to five (5) consecutive days at a time. **Pre-certification is required.**
If your child needs dental or eye care	Children's eye exam	No Charge, deductible waived	50% coinsurance, deductible waived	**Calendar Year Limit:** One (1) exam per child.
	Children's glasses	No Charge, deductible waived	50% coinsurance, deductible waived	Lenses/frames available through VSP Pediatric exchange. **Calendar Year Limit:** Lenses and/or frames covered once per calendar year.
	Children's dental check-up	No Charge, deductible waived		Dental benefits available through Cigna. **Calendar Year Limit:** Two (2) check-ups per child.

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

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)
- Contraceptives (unless medically necessary)
- Cosmetic Surgery
- Infertility Treatment
- Long-Term 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]
- Dental Care
- 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
- Routine Eye Care [Limited to one (1) exam per calendar year]

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

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, kwiijigo holne' 1-833-740-3260.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$1,800
Specialist cost-sharing	0%
Hospital (facility) cost sharing	20%
Other cost sharing	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,800
Specialist cost-sharing	0%
Hospital (facility) cost sharing	20%
Other cost sharing	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$900
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,750**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,800
Specialist cost-sharing	0%
Hospital (facility) cost sharing	20%
Other cost sharing	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$100
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

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