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**	See the Common Medical Events chart below for your costs for services this plan covers.
	Per participant:	$0	$0	
	Per family:	$0	$0	
Are there services covered before you meet your deductible?	Not Applicable.			Not Applicable.
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:	$8,550	$17,100	
	Per family:	$17,100	$34,200	
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, and certain specialty pharmacy drugs considered non-essential health benefits.			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	$35 copayment	$70 copayment	The office visit copayment applies to all services rendered in a provider's office, except for advanced imaging, labs, and x-rays.
	Specialist visit	$60 copayment	$120 copayment	
	Preventive care/screening/ immunization	No Charge	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)	**X-Rays**: $150 copayment **Labs:** $60 copayment	**X-Rays:** $300 copayment **Labs:** $120 copayment	——————————none——————————
	Imaging (CT/PET scans, MRIs)	$600 copayment	$1,200 copayment	**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:** $10 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. 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 Insulin and Diabetic Drugs:** Thirty (30) Day Supply: $25 copayment, deductible waived Sixty (60) Day Supply: $50 copayment, deductible waived Ninety (90) Day Supply: $75 copayment, deductible waived
	Preferred brand drugs	**Thirty (30) Day Supply:** 30% coinsurance ($25 minimum, $75 maximum per prescription) **Thirty-One (31) to Ninety (90) Day Supply:** 30% coinsurance ($62.50 minimum, $187.50 maximum per prescription)		
	Non-preferred brand drugs	**Thirty (30) Day Supply:** 40% coinsurance ($50 minimum, $100 maximum per prescription) **Thirty-One (31) to Ninety (90) Day Supply:** 40% coinsurance ($125 minimum, $250 maximum per prescription)		
	Specialty drugs	Applicable benefit as shown above		

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$700 copayment	$1,400 copayment	**Pre-certification is required.**
	Physician/surgeon fees	No Charge		
If you need immediate medical attention	Emergency room care	$500 copayment		Copayment waived if admitted within twenty-four (24) hours.
	Emergency medical transportation	$600 copayment		——————————none——————————
	Urgent care	$100 copayment		Urgent care copayment includes all services rendered during an urgent care visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copayment	$3,000 copayment	Copayment applies per day for the first three (3) days, then covered at No Charge. **Pre-certification is required.**
	Physician/surgeon fees	No Charge		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment	$70 copayment	**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	**Facility Charges:** $1,500 copayment **Professional Charges:** No Charge	**Facility Charges:** $3,000 copayment **Professional Charges:** No Charge	Copayment applies per day for the first three (3) days, then covered at No Charge. **Pre-certification is required.**

* 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 are pregnant	Office visits	**Prenatal Care:** No Charge* **Postnatal Care:** Primary Care Physician: $35 copayment Specialist: $60 copayment	**Prenatal Care:** Not Covered **Postnatal Care:** Primary Care Physician: $70 copayment Specialist: $120 copayment	*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 preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). **Copayment applies per day for the first three (3) days, then covered at No Charge.
	Childbirth/delivery professional services	No Charge		
	Childbirth/delivery facility services	$1,500 copayment**	$3,000 copayment**	
If you need help recovering or have other special needs	Home health care	$50 copayment per day	$100 copayment per day	**Pre-certification is required.**
	Rehabilitation services	$50 copayment **Chiropractic Services:** $60 copayment per visit	$100 copayment **Chiropractic Services:** $120 copayment per visit	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	$250 copayment per day	$500 copayment per day	**Calendar Year Limit:** One hundred (100) days per plan participant. **Pre-certification is required.**
	Durable medical equipment	$130 copayment per item	$260 copayment per item	**Pre-certification is required for all rentals and any purchase over $1,500.**
	Hospice services	$75 copayment per day	$150 copayment per day	Respite care is limited to five (5) consecutive days at a time. **Pre-certification is required.**

* 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 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)
- Contraceptives (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.

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	$0
Specialist copayment	$60
Hospital (facility) copayment	$1,500
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	$0
Copayments	$5,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,460**

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) copayment	$1,500
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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) copayment	$1,500
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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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