

 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 <https://ConcordiaPlans.Quantum-Health.com> or call 1-833-740-3260. For 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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$3,200 individual/\$6,400 family network \$9,600 individual/\$19,200 family non-network (medical, mental health and pharmacy combined)	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> (embedded) until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is not subject to <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You do not have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,400 individual/\$12,800 family network \$19,200 individual/\$38,400 family non-network (medical, mental health and pharmacy combined)	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members on this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> (embedded) until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	DAW penalties (difference in cost between generic and brand if generic alternative is available), <a href="#">specialty drug copayment</a> assistance programs, <a href="#">premiums</a> , <a href="#">balance-billing</a> (unless <a href="#">balance-billing</a> is prohibited) charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://ConcordiaPlans.Quantum-Health.com">https://ConcordiaPlans.Quantum-Health.com</a> or call 1-833-740-3260 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care provider's office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Surgery performed in office setting is subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">deductible</a> waived	Not covered	You may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Immunizations for children through age 4 are no charge deductible waived network and non-network.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Outpatient: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> Preferred Independent Lab: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Diagnostic test</a> during an office visit is subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required for MRI/MRA and PET scans.
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	\$0 for preventive generic prescriptions and generic diabetic supplies. These are not subject to the <a href="#">deductible</a> .  Otherwise: \$10 <a href="#">copay</a> : 30 days \$25 <a href="#">copay</a> /prescription: 31-90 days	No coverage	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand <a href="#">copayment</a> amount.



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)	
<p>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://ConcordiaPlans.Quantum-Health.com">https://ConcordiaPlans.Quantum-Health.com</a> or call 1-833-740-3260.</p>	Preferred brand drugs	<p>30% <a href="#">coinsurance</a> (\$25 minimum, \$75 maximum): 30 days</p> <p>30% <a href="#">coinsurance</a> (\$62.50 minimum, \$187.50 maximum): 31-90 days</p> <p>Preferred Brand diabetic and insulin drugs are not subject to the <a href="#">deductible</a>.</p> <p>For Preferred Brand insulin drugs only:            30-day supply: \$25 <a href="#">copay</a>            60-daysupply: \$50 <a href="#">copay</a>            90-daysupply: \$75 <a href="#">copay</a></p>	No coverage	<p>Certain maintenance medications are available at a 90 day supply at select pharmacies. Coverage is only available for a day supply at Walgreens or through mail order.</p> <p><a href="#">Deductible</a> may not apply to <a href="#">preventive care</a> drugs as outlined in the Affordable Care Act (PPACA). Certain prescriptions require prior authorization before the drug can be dispensed.</p>
	Non-preferred brand drugs	<p>40% <a href="#">coinsurance</a> (\$50 minimum, \$100 maximum): 30 days</p> <p>40% <a href="#">coinsurance</a> (\$125 minimum, \$250 maximum): 31-90 days</p> <p>Diabetic drugs are not subject to the <a href="#">deductible</a>.</p>	No coverage	
	<a href="#">Specialty drugs</a>	Applicable benefit as shown above.	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<p><a href="#">Preauthorization</a> required for outpatient surgeries.</p>
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">network deductible</a>		None



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)	
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">network deductible</a>		None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> after <a href="#">network deductible</a>		None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required for inpatient facility admissions.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Office visits	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.  <a href="#">Preauthorization</a> required for partial hospitalization and intensive outpatient for mental health/substance abuse
	Outpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>If you are pregnant</b>	Office visits*	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required for inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. <a href="#">cost sharing</a> does not apply for preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *Processed as a global maternity service which includes pre-natal, post-natal and the delivery service.
	Childbirth/delivery professional services*	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required for home health care services.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Medical necessity will be reviewed after 20 visits.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage limited to 100 days. <a href="#">Preauthorization</a> required for skilled nursing inpatient admissions.



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)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	A <a href="#">preauthorization</a> may apply for certain equipment. All rentals and any purchases over \$1,500 require <a href="#">preauthorization</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Includes bereavement counseling. <a href="#">Preauthorization</a> required for hospice care services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### 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)       | • Dental care (Adult)   | • Routine eye care (Adult) |
| • Cosmetic surgery                            | • Infertility treatment | • Routine foot care        |
| • Contraceptives (unless medically necessary) | • Long-term 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                   | • Hearing aids (up to age 19)                           | • Private-duty nursing |
| • Bariatric surgery             | • Non-emergency care when traveling outside of the U.S. |                        |
| • Chiropractic care (26 visits) |   |                        |

**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](mailto: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 <http://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.

#### **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.*

---



**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](#) \$3,200
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$10
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,670</b>

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

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

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

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist](#) [coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.