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:
What is the overall deductible?	$6,000 individual/$12,000 family network $18,000 individual/$36,000 family non-network (medical, mental health and pharmacy combined)	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 (embedded) 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 is not subject to deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. 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?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,900 individual/$13,800 family network $20,700 individual/$41,400 family non-network (medical, mental health and pharmacy combined)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limit (embedded) until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	DAW penalties (difference in cost between generic and brand if generic alternative is available), specialty drug copayment assistance programs, premiums, balance-billing (unless balance-billing is prohibited) charges, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://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	20% coinsurance after deductible	40% coinsurance after deductible	Surgery performed in office setting is subject to deductible and coinsurance.
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge deductible waived	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Immunizations for children through age 4 are no charge deductible waived network and non-network.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient: 20% coinsurance after deductible Preferred Independent Lab: 10% coinsurance after deductible	40% coinsurance after deductible	Diagnostic test during an office visit is subject to applicable deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for MRI/MRA and PET scans.

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: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations & Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://ConcordiaPlans.Quantum-Health.com or call 1-833-740-3260.	Generic drugs	$0 for preventive generic prescriptions and generic diabetic supplies. These are not subject to the deductible. Otherwise: $10 copay: 30 days $25 copay/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 copayment amount. 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. Deductible may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Certain prescriptions require prior authorization before the drug can be dispensed.
	Preferred brand drugs	30% coinsurance ($25 minimum, $75 maximum): 30 days 30% coinsurance ($62.50 minimum, $187.50 maximum): 31-90 days Preferred Brand diabetic and insulin drugs are not subject to the deductible. For Preferred Brand insulin drugs only: 30-day supply: $25 copay 60-daysupply: $50 copay 90-daysupply: $75 copay	No coverage	
	Non-preferred brand drugs	40% coinsurance ($50 minimum, $100 maximum): 30 days 40% coinsurance ($125 minimum, $250 maximum): 31-90 days Diabetic drugs are not subject to the deductible.	No coverage	
	Specialty drugs	Applicable benefit as shown above.	No coverage	Specialty prescriptions may be obtained from a specialty pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for outpatient surgeries.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance after network deductible		None
	Emergency medical transportation	20% coinsurance after network deductible		None
	Urgent care	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	Preauthorization required for inpatient facility admissions.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for partial hospitalization and intensive outpatient for mental health/substance abuse
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits*	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive care. 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% 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 health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for home health care services.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Medical necessity will be reviewed after 20 visits.

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)	
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage limited to 100 days. Preauthorization required for skilled nursing inpatient admissions.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	A preauthorization may apply for certain equipment. All rentals and any purchases over $1,500 require preauthorization.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Includes bereavement counseling. Preauthorization 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)
- Cosmetic surgery
- Contraceptives (unless medically necessary)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic care (26 visits)
- Hearing aids(up to age 19)
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing

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 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, 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.

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	$6,000
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,870**

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

The plan's overall deductible	$6,000
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

The plan's overall deductible	$6,000
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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