

 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 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 1-833-740-3260 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<p><u>In-network</u>:                      Tier 1 - \$3,200/individual or \$6,400/family                      Tier 2 - \$4,200/individual or \$8,400/family                      (medical, prescription and mental health combined)                      All in-network deductible payments will cross accumulate to both Tier 1 and Tier 2.</p> <p><u>Out-of-network</u>:                      \$9,600/individual or \$19,200/family                      (medical, prescription and mental health combined)</p>	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> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . See the Common Medical Events chart on page 2 for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <u>In-network</u> <a href="#">preventive care</a> services are not subject to a <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. A <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><u>In-network</u>:                      Tier 1 - \$3,200/individual or \$6,400/family                      Tier 2 - \$8,050/individual or \$16,100/family                      (medical, prescription and mental health combined)                      All in-network out-of-pocket payments will cross accumulate to both Tier 1 and Tier 2.</p> <p><u>Out-of-network</u>:                      \$19,200/individual or \$38,400/family (medical, prescription and mental health combined)</p>	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 in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties and health care this <a href="#">plan</a> doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <a href="#">out-of-pocket</a> limits. The cost of these drugs (if reimbursed by the manufacturer at no cost to you) won't be applied to your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://www.concordiaplans.quantum-health.com">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 <a href="#">referral</a> .



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
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Out-of-network provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/Screening/immunization</a>	Tier 1 – No Charge Tier 2 – No Charge <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-network provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available by calling 1-833-740-3260.</p>	Generic, Preferred brand and Non-preferred brand drugs	No Charge after Tier 1 Deductible	Not Covered	<p>Covers up to a 30 days supply (retail pharmacy); 31-90 days supply through Benecard Central Fill mail order pharmacy. Some medications require <a href="#">preauthorization</a> or step therapy program adherence. <a href="#">Specialty Drugs</a> have to be purchased through Benecard Central Fill, a specialty mail-order pharmacy available through EmpiRx Health, however, first fill is allowed at a retail pharmacy. Exceptions may apply. If a prescription is presented with a “dispense as written” (DAW) for a brand-named drug but an equivalent generic drug is available, the member will pay the <a href="#">copay</a> for the brand-named drug plus the difference in cost between the generic drug and the brand-named drug. The cost difference (penalty) will not apply to the <a href="#">deductible</a>/out-of-pocket maximum.</p> <p>Concordia Plans has arranged for Payer Matrix to assist you in obtaining financial assistance for <a href="#">specialty drugs</a>. You need to enroll with Payer Matrix to obtain such assistance. If you enroll with Payer Matrix, but are not eligible for financial assistance, your benefits will process in accordance with your <a href="#">plan</a> design (i.e. applicable <a href="#">deductible</a> and <a href="#">copayment</a> amounts). If you are eligible but refuse to enroll in Payer Matrix, you will have to pay the full cost of the drug, unless you file an <a href="#">appeal</a>.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge	No Charge	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	If <a href="#">medically necessary</a>
	<a href="#">Urgent care</a>	No Charge	40% <a href="#">coinsurance</a>	If a separate facility charge is billed, the hospital facility fee benefits will apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for all hospital admissions.
	Physician/surgeon fees	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
If you are pregnant	Office visits	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply for prenatal visits.	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> required for all hospital admissions.
	Childbirth/delivery professional services	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days per calendar year covered.
	<a href="#">Durable medical equipment</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	A <a href="#">preauthorization</a> may apply for certain equipment.
	<a href="#">Hospice services</a>	Tier 1 – No Charge Tier 2 - 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	One exam per calendar year.
	Children's Glasses	No charge <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	Lenses and/or frames covered once per calendar year.
	Children's dental check-up	No charge <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	Two exams/calendar year.

### Excluded services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortion (unless <a href="#">medically necessary</a>)</li> <li>• Contraceptives (unless <a href="#">medically necessary</a>)</li> <li>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care (except for certain medical conditions)</li> <li>• Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (must be <a href="#">medically necessary</a>, such as for chronic pain management or the prevention or treatment of nausea associated with surgery, chemotherapy, or pregnancy)</li> <li>• Bariatric Surgery (<a href="#">preauthorization</a> required)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (limited to 26 visits/plan year)</li> <li>• Dental Care (adult)</li> <li>• Hearing Aids (cochlear and BAHA implants are covered; other aids available only for children under age 19)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency Care Traveling Outside U.S.</li> <li>• Private Duty Nursing (requirements and restrictions apply to service and service provider)</li> <li>• Routine Eye Care (adult)</li> </ul>

**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.

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost sharing	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost sharing	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,220

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$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.