

 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>	\$3,500 individual/\$7,000 family network \$10,500 individual/\$21,000 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> , the overall family <a href="#">deductible</a> (non-embedded) must be met before the <a href="#">plan</a> begins to pay.
<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>	\$7,000 individual/\$14,000 family network \$21,000 individual/\$42,000 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> , the overall family <a href="#">out-of-pocket limit</a> (non-embedded) must be 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, penalties 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.
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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 <a href="#">provider's</a> office or clinic	<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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <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.



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><b>If you need drugs to treat your illness or condition</b> 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>	Generic drugs	<p>\$0 for preventive generic prescriptions and generic diabetic supplies. These are not subject to the <a href="#">deductible</a>.</p> <p>Otherwise: \$10 <a href="#">copay</a>: 30 days \$25 <a href="#">copay</a>/prescription: 31-90 days after <a href="#">deductible</a></p>	No coverage	<p>Some medications require <a href="#">preauthorization</a> or step therapy program adherence. <a href="#">Specialty Drugs</a> must be purchased through Prescription Mart, a specialty mail-order pharmacy available through EmpiRx Health, however, a first fill is allowed at a retail pharmacy. Exceptions may apply.</p> <p>If a prescription is presented with a “dispense as written” (DAW) for a brand drug but an equivalent generic drug is available, the member will pay the <a href="#">copay</a> for the brand drug plus the difference in cost between the generic drug and the brand drug. The cost difference (penalty) will not apply to the <a href="#">deductible</a> or out-of-pocket maximum.</p>
	Preferred brand drugs	<p>30% <a href="#">coinsurance</a> (\$25 minimum, \$75 maximum): 30 days 30% <a href="#">coinsurance</a> (\$62.50 minimum, \$187.50 maximum): 31-90 days after <a href="#">deductible</a></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-day supply: \$50 <a href="#">copay</a> 90-day supply: \$75 <a href="#">copay</a></p>	No coverage	
	Non-preferred brand drugs	<p>40% <a href="#">coinsurance</a> (\$50 minimum, \$100 maximum): 30 days 40% <a href="#">coinsurance</a> (\$125 minimum, \$250 maximum): 31-90 days after <a href="#">deductible</a></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	



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)	
				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.
<b>If you have outpatient surgery</b>	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>	<a href="#">Preauthorization</a> required for outpatient surgeries.
	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 immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">network deductible</a>		None
	<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 8 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Outpatient services	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 partial hospitalization and intensive outpatient for mental health/substance abuse
	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="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required.
	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>	



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 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 combined for Physical and Occupational Therapy. Speech Therapy will be reviewed for medical necessity 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.
	<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.
<b>If your child needs dental or eye care</b>	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.

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

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**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](#) 3,500
- [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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$10
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,870</b>

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

- The [plan's](#) overall [deductible](#) 3,500
- [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>
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**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](#) 3,500
- [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>
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**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.