
 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 1-888-927-7526. 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 1-888-927-7526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-network:</b> \$600/individual or \$1,200/family (medical and mental health combined) <b>Out-of-network:</b> \$1,200/individual or \$2,400/family (medical and mental health combined) <b>Coinsurance</b> and <b>copays</b> not included.	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <b>In-network</b> <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> ?	<b>In-network</b> Individual: \$3,000 plus applicable <a href="#">copays</a> Family: \$6,000 plus applicable <a href="#">copays</a> <b>Out-of-network</b> Individual: \$7,200 plus applicable <a href="#">copays</a> Family: \$14,400 plus applicable <a href="#">copays</a>	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> ?	Penalties, <a href="#">copayments</a> , <a href="#">premiums</a> , <a href="#">balance billing</a> charges, <a href="#">prescription drugs</a> and health care this <a href="#">plan</a> doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <a href="#">out-of-pocket limits</a> . The cost of these drugs (if reimbursed by the manufacturer at no cost to you) will not be applied towards 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.bluecrossmn.com/concordia">https://www.bluecrossmn.com/concordia</a> or call 1-800-810-BLUE (2583) 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> .
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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)	Out-of-network provider (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	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$60 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	If a separate facility charge is billed, the hospital facility fee benefits will apply.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$60 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	If a separate facility charge is billed, the hospital facility fee benefits will apply.
	<a href="#">Preventive care/Screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by calling 1-888-927-7526	Generic drugs	Retail: \$15 <a href="#">copay</a> <a href="#">Deductible</a> does not apply. Mail: \$25 <a href="#">copay</a> <a href="#">Deductible</a> does not apply.	Retail: \$15 <a href="#">copay</a> plus charges above <a href="#">allowed amount</a> <a href="#">Deductible</a> does not apply.	Covers up to a 30-day supply (retail pharmacy); 31 to 90-day supply (through Express Scripts mail order pharmacy or Walgreens only). Some medications require <a href="#">preauthorization</a> or step therapy program adherence. <a href="#">Specialty Drugs</a> have to be purchased through Accredo, a specialty mail-order pharmacy available through Express Scripts, however, first fill is allowed at a retail pharmacy. Exceptions may apply.
	Preferred brand drugs	Retail: \$30 <a href="#">copay</a> <a href="#">Deductible</a> does not apply. Mail: \$60 <a href="#">copay</a> <a href="#">Deductible</a> does not apply.	Retail: \$30 <a href="#">copay</a> plus charges above <a href="#">allowed amount</a> <a href="#">Deductible</a> does not apply.	
	Non-preferred brand drugs	Retail: \$60 <a href="#">copay</a> <a href="#">Deductible</a> does not apply. Mail: \$120 <a href="#">copay</a> <a href="#">Deductible</a> does not apply.	Retail: \$60 <a href="#">copay</a> plus charges above <a href="#">allowed amount</a> <a href="#">Deductible</a> does not apply.	
	<a href="#">Specialty drugs</a>	Applicable Generic Drugs, Preferred brand drugs or Non-preferred brand drug benefit shown above.	Applicable Generic Drugs, Preferred brand drugs or Non-preferred brand drug benefit shown above.	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 (penalty).  For <a href="#">Specialty Drugs</a> , see "Important Questions" regarding the <a href="#">plan's out-of-pocket limit</a> .

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$120 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$120 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	<a href="#">Copay</a> waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	If <a href="#">medically necessary</a> .
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$60 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for all hospital admissions. (Out-of-Network: \$500 penalty if <a href="#">preauthorization</a> is not obtained.)
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$60 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	No charge for laboratory tests, psychological testing, or other services. Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	No charge <a href="#">Deductible</a> does not apply.	No charge <a href="#">Deductible</a> does not apply.	<a href="#">Preauthorization</a> required for all hospital admissions. (Out-of-Network: \$500 penalty if <a href="#">preauthorization</a> is not obtained.)
If you are pregnant	Office visits	\$30 <a href="#">copay</a> /pregnancy <a href="#">Deductible</a> does not apply.	\$60 <a href="#">copay</a> /pregnancy <a href="#">Deductible</a> does not apply.	None
	Childbirth/delivery professional services	No additional charge	No additional charge	Physician's charges for prenatal/postnatal care and delivery covered by one <a href="#">copay</a> per pregnancy. Other services: <a href="#">deductible</a> / <a href="#">coinsurance</a> apply.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for all hospital admissions. (Out-of-Network: \$500 penalty if <a href="#">preauthorization</a> is not obtained.)
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Up to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Rental or purchase available dependent upon cost and duration. A <a href="#">preauthorization</a> may apply for certain equipment.
	<a href="#">Hospice services</a>	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 <b>Deductible</b> does not apply.	50% <b>coinsurance</b> <b>Deductible</b> does not apply.	One exam/calendar year.
	Children's glasses	No charge <b>Deductible</b> does not apply.	50% <b>coinsurance</b> <b>Deductible</b> does not apply.	Lenses and/or frames covered once per calendar year.
	Children's dental check-up	No charge <b>Deductible</b> does not apply.	No charge <b>Deductible</b> does not apply.	Two check-ups/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> <li>Experimental &amp; Investigational Procedures</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 (<i>except for certain medical conditions</i>)</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 (<i>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</i>)</li> <li>Bariatric Surgery (<i><a href="#">preauthorization</a> required through Blue Cross and Blue Shield of Minnesota</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (<i>limited to 26 visits/plan year with a limitation to the type of services a chiropractor can perform</i>)</li> <li>Dental Care (<i>adult</i>)</li> <li>Hearing Aids (<i>cochlear and BAHA implants are covered; other aids available only for children under age 19</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency Care Traveling Outside U.S. (<i>in-network benefits apply</i>)</li> <li>Private Duty Nursing (<i>requirements and restrictions apply to service and service provider</i>)</li> <li>Routine Eye Care (<i>adult</i>)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact CPS 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 [www.HealthCare.gov](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](#). For more information about your rights, this notice, or assistance, contact CPS at 1-888-927-7526 or [info@ConcordiaPlans.org](mailto:info@ConcordiaPlans.org). 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

For more information about limitations and exceptions, Call 1-888-927-7526 or visit us at [www.ConcordiaPlans.org](http://www.ConcordiaPlans.org)

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 1-800-793-6922.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-793-6922.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-793-6922.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-793-6922.

-----*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>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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
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In this example, Peg would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$1,881
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,661

### 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>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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
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In this example, Joe would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$1,095
<a href="#">Coinsurance</a>	\$252
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,002

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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
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In this example, Mia would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$95
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$755

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