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 deductible? | In-network: $4,500/individual or $9,000/family<br>Out-of-network: $13,500/individual or $27,000/family (medical, mental health and pharmacy) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. If you have other family members on the plan, each family member must meet their own individual deductible 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. Well-child care, prenatal care, preventive generic drugs, generic diabetic supplies and Network Preventive care services are covered before you meet your 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 don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-network: $6,900/individual or $13,800/family<br>Out-of-network: $20,700/individual or $41,400/family (medical, mental health and pharmacy) | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, penalties and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.bluecrossmnonline.com or call 1-866-873-5943 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) | Out-of-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/ Immunization | No charge<br>Deductible does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| If you need drugs to treat your illness or condition.<br>More information about prescription drug coverage is available by calling 1-888-927-7526 | Generic drugs | $0 for preventive generic prescriptions and generic diabetic supplies. These are not subject to the deductible.<br><br>Otherwise:<br>$10 copay: Retail (30-day)<br>$25 copay: 31-90days | $0 for preventive generic prescriptions and generic diabetic supplies plus charges above allowed amount. These are not subject to the deductible.<br>Otherwise:<br>$10 copay plus charges above allowed amount. | Covers up to a 30-day supply (retail prescription); 31-90-day supply (through Express Scripts mail order pharmacy or Walgreens only). Some medications require preauthorization or step therapy program adherence. Specialty Drugs 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.<br><br>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 copay for the brand-named drug plus the difference in cost between the generic drug and the brand-named drug. The cost |
| | Preferred Brand | 30% coinsurance ($25 minimum, $75 maximum): Retail (30-days)<br>30% coinsurance ($62.50 minimum, $187.50 maximum): 31-90 days<br>Preferred Brand diabetic and insulin drugs are not subject to the deductible.<br><br>For Preferred Brand insulin only:<br>30-day supply: $25 copay<br>60-day supply: $50 copay<br>90-day supply: $75 copay | Applicable retail benefit plus charges above allowed amount. | |
| | Non-preferred Brand | 40% coinsurance ($50 minimum, $100 maximum): Retail (30-days) | Applicable retail benefit plus | |

| 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 | |
| | | 40% coinsurance ($125 minimum, $250 maximum): 31-90 days Diabetic drugs are not subject to the deductible | charges above allowed amount. | difference (penalty) will not apply to the deductible or out-of-pocket maximum. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | If medically necessary |
| | Urgent care | 20% coinsurance | 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required for all hospital admissions. (Out-of-Network: $500 penalty if preauthorization is not obtained.) |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 40% coinsurance | Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization required for all hospital admissions. (Out-of-Network: $500 penalty if preauthorization is not obtained.) |
| If you are pregnant | Office visits | Prenatal Care: No charge Postnatal Care: 20% coinsurance | Prenatal Care: Not covered Postnatal Care: 40% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required for all hospital admissions. (Out-of-Network: $500 penalty if preauthorization is not obtained.) |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |

| 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 | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Preauthorization required after 20 days. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Preauthorization required after 20 visit for occupational therapy, physical therapy and speech therapy.<br>26 visit maximum for chiropractic<br>36 visit maximum for cardiac therapy |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Preauthorization required after 20 visit for occupational therapy, physical therapy and speech therapy.<br>Must be medically necessary. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 100 days per person per benefit period. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Rental or purchase available dependent upon cost and duration. A preauthorization may apply for certain equipment. |
| | Hospice services | 20% coinsurance | 40% coinsurance | None |
| 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)
- Contraceptives (unless medically necessary)
- Cosmetic Surgery (except as specified in Plan benefits)
- Dental Care (Adult/Child)
- Habilitation (unless medically necessary)
- Infertility Treatment
- Long-Term Care
- Private Duty Nursing
- Routine eye care (Adult/Child)
- 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 the U.S.

**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*. 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 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*. 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 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 1-855-793-6931

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

*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 network prenatal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $4,500 |
| Specialist copayment | 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 | $4,500 |
| Copayments | $10 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| The total Peg would pay is | $5,710 |

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

| | |
|---|---|
| The plan's overall deductible | $4,500 |
| Specialist copayment | 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 | $200 |
| The total Joe would pay is | $2,800 |

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

| | |
|---|---|
| The plan's overall deductible | $4,500 |
| Specialist copayment | 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.