



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> \$6,000 /individual or \$12,000/family <b>Out-of-network:</b> \$18,000 /individual or \$36,000/family (medical, mental health and pharmacy)	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. This <a href="#">plan</a> has an embedded <a href="#">deductible</a> . 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. Well-child care, prenatal care, preventive generic drugs, generic diabetic supplies and Network <a href="#">Preventive care</a> services are covered before you meet your <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> .
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> \$6,900/individual or \$13,800/family <b>Out-of-network:</b> \$20,700/individual or \$41,400/family (medical, mental health and pharmacy)	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 limits</a> . 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="http://www.umar.com">www.umar.com</a> or call 1-800-826-9781 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
		In-network (You will pay the least)	Out-of-network (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	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<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 you need 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> office & outpatient settings; 10% <a href="#">coinsurance</a> for Preferred Independent lab and <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

<p><b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available by calling 1-877-241-7123.</p>	Generic drugs	<p>\$0 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>: Retail (30-day)            \$25 <a href="#">copay</a>: Mail Order (90-day)</p>	Same as In-network benefit	<p>Covers up to a 30-day supply (retail prescription); 31-90 day 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> or 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>
	Preferred brand drugs	<p>30% <a href="#">coinsurance</a> (\$25 minimum, \$75 maximum: Retail (30-day)            30% <a href="#">coinsurance</a> (\$62.50 minimum, \$187.50 maximum): Mail Order (31-90 days)</p> <p>The <a href="#">deductible</a> does not apply to diabetic drugs.</p>	Same as In-network benefit	
	Non-preferred brand drugs	<p>40% <a href="#">coinsurance</a> (\$50 minimum, \$100 maximum): Retail (30-days)            40% <a href="#">coinsurance</a> (\$125 minimum, \$250 maximum): Mail Order (31-90 days)</p> <p>The <a href="#">deductible</a> does not apply to diabetic drugs.</p>	Same as In-network benefit	
<p><b>If you have outpatient</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

surgery	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>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<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>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
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> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	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	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.
If you are pregnant	Office visits	Prenatal Care: No charge Postnatal Care: 20% <a href="#">coinsurance</a>	Prenatal Care: Not covered Postnatal Care: 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).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

	Childbirth/delivery facility services	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>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	16 Maximum hours per day 60 Maximum visits per calendar year <a href="#">Preauthorization</a> required after 20 days
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	40 visit for occupational therapy 40 visits for physical therapy 26 visits for chiropractic 36 visits for cardiac therapy 40 visits for speech therapy
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	40 visits for occupational therapy 40 visits for physical therapy 40 visits for speech therapy Must be <a href="#">medically necessary</a> .
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 Maximum days per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.
	<a href="#">Durable medical equipment</a>	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>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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](#) 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
- Dental care (Adult/child)
- Experimental & Investigational Procedures
- Habilitation services (unless [medically necessary](#))
- Infertility treatment
- Long-term care
- 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.
- Private-duty nursing (Outpatient care if [home health care](#) is not available)

**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 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 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne 1-800-826-9781.

-----*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>	\$6,000
■ <a href="#">Specialist coinsurance</a>	20%
■ 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>	\$6,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$800
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$6,910

### 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>	\$6,000
■ <a href="#">Specialist coinsurance</a>	20%
■ 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>	\$2,300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,800

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist coinsurance</a>	20%
■ 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>	\$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.