




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: |
|---|---|---|
| <p>What is the overall deductible?</p> | <p>In-network: \$1,800/individual or \$3,600/family (medical and mental health combined) Out-of-network: \$3,600/individual or \$7,200/family (medical and mental health combined) Coinsurance and copays not included.</p> | <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. In-network preventive care services are not subject to a deductible.</p> | <p>This plan covers some items and services even if you haven't yet met the deductible amount. A copayment or coinsurance may apply.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>In-network Individual: \$5,400 plus applicable copays Family: \$10,800 plus applicable copays Out-of-network Individual: \$14,400 plus applicable copays Family: \$28,800 plus applicable copays</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Penalties, copayments, premiums, balance billing charges, prescription drugs and health care this plan doesn't cover. In addition, certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. 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.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

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| Will you pay less if you use a network provider ? | Yes. See https://www.bluecrossmn.com/concordia or call 1-800-810-BLUE (2583) 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 (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | No charge | If a separate facility charge is billed, the hospital facility fee benefits will apply. |
| | Specialist visit | No charge | No charge | If a separate facility charge is billed, the hospital facility fee benefits will apply. |
| | Preventive care/Screening/immunization | No charge 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 | 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 drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-888-927-7526 | Generic drugs | Retail: \$15 copay Deductible does not apply. Mail: \$25 copay Deductible does not apply. | Retail: \$15 copay plus charges above allowed amount Deductible does not apply. | Covers up to a 30-day supply (retail pharmacy); 31-90-day supply (through Express Scripts mail order pharmacy or Walgreens only). Some medications 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. 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 (penalty). Certain specialty medications are eligible for the SaveOnSP program. Members who are taking eligible SaveOnSP medications will be requested to enroll in the program. If a member chooses not to participate in SaveOnSP, they will pay a higher cost share. For Specialty Drugs , see “Important Questions” regarding the plan’s out-of-pocket limit . |
| | Preferred brand drugs | Retail: \$30 copay Deductible does not apply. Mail: \$60 copay Deductible does not apply. | Retail: \$30 copay plus charges above allowed amount Deductible does not apply. | |
| | Non-preferred brand drugs | Retail: \$60 copay Deductible does not apply. Mail: \$120 copay Deductible does not apply. | Retail: \$60 copay plus charges above allowed amount Deductible does not apply. | |
| | Specialty drugs | 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 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 | \$120 copay /visit Deductible does not apply. | \$120 copay /visit Deductible does not apply. | Copay waived if admitted within 24 hours. |

| 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) | |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | If medically necessary . |
| | Urgent care | \$35 copay /visit Deductible does not apply. | 40% 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 | No charge Deductible does not apply. | No charge Deductible does not apply. | Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge. |
| | Inpatient services | No charge Deductible does not apply. | No charge Deductible does not apply. | Preauthorization required for all hospital admissions. (Out-of-Network: \$500 penalty if preauthorization is not obtained.) |
| If you are pregnant | Office visits | No charge | No charge | Plan covers 100% of eligible charges after your deductible has been met. |
| | Childbirth/delivery professional services | No charge | No charge | Physician's charges for delivery subject to deductible , but not subject to coinsurance . Other services: deductible/coinsurance apply. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Preauthorization required for all hospital admissions. (Out-of-Network: \$500 penalty if preauthorization is not obtained.) |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | None |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | None |
| | Habilitation services | 20% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Up to 100 days/calendar year. |
| | 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 |

| 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 Deductible does not apply. | 50% coinsurance Deductible does not apply. | One exam/calendar year. |
| | Children's glasses | No charge Deductible does not apply. | 50% coinsurance Deductible does not apply. | Lenses and/or frames covered once per calendar year. |
| | Children's dental check-up | No charge Deductible does not apply. | No charge Deductible does not apply. | Two check-ups/calendar year. |

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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Abortion (unless medically necessary) • Contraceptives (unless medically necessary) • Cosmetic Surgery • Experimental & Investigational Procedures | <ul style="list-style-type: none"> • Infertility Treatment • Long-Term Care | <ul style="list-style-type: none"> • Routine Foot Care (<i>except for certain medical conditions</i>) • Weight Loss Programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture (<i>must be medically necessary, such as for chronic pain management or the prevention or treatment of nausea associated with surgery, chemotherapy, or pregnancy</i>) • Bariatric Surgery (preauthorization required) | <ul style="list-style-type: none"> • Chiropractic Care (<i>limited to 26 visits/plan year</i>) • Dental Care (<i>adult</i>) • Hearing Aids (<i>cochlear and BAHA implants are covered; other aids available only for children under age 19</i>) | <ul style="list-style-type: none"> • Non-Emergency Care Traveling Outside U.S. (<i>in-network benefits apply</i>) • Private Duty Nursing (<i>requirements and restrictions apply to service and service provider</i>) • Routine Eye Care (<i>adult</i>) |

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 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 1-800-793-6922.

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, kwijigo 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 [plan's](#) overall [deductible](#) \$1,800
- [Specialist copayment](#) \$0
- 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 | \$1,800 |
| Copayments | \$60 |
| Coinsurance | \$1,965 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,885 |

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist copayment](#) \$0
- 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 | \$1,800 |
| Copayments | \$855 |
| Coinsurance | \$170 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,880 |

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist copayment](#) \$0
- 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 | \$1,800 |
| Copayments | \$0 |
| Coinsurance | \$25 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,825 |

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