
 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 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. 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 <a href="#">Network 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.	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.bluecrossmnonline.com">www.bluecrossmnonline.com</a> or call 1-866-873-5943 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
		Network Provider (You will pay the least)	Out-of-Network Provider	
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 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>	
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	\$0 for preventive generic prescriptions and generic diabetic supplies. These are not subject to the <a href="#">deductible</a> .  Otherwise: \$10 <a href="#">copay</a> : 30 days \$25 <a href="#">copay</a> : 31-90days	\$0 for preventive generic prescriptions and generic diabetic supplies plus charges above <a href="#">allowed amount</a> . These are not subject to the <a href="#">deductible</a> . Otherwise: \$10 <a href="#">copay</a> plus charges above <a href="#">allowed amount</a> .	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 <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.  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-
	Preferred Brand	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  Preferred Brand diabetic and insulin drugs are not subject to the <a href="#">deductible</a> .	30% <a href="#">coinsurance</a> (\$25 minimum, \$75 maximum) plus charges above <a href="#">allowed amount</a> .	

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

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	
		For Preferred Brand insulin drugs (In-Network 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>		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.
	Non-preferred Brand	40% <a href="#">coinsurance</a> (\$50 minimum, \$100 maximum): 30 days 40% <a href="#">coinsurance</a> (\$125 minimum, \$250 maximum): 31-90 days  Diabetic drugs are not subject to the <a href="#">deductible</a> .	40% <a href="#">coinsurance</a> (\$50 minimum, \$100 maximum) plus charges above <a href="#">allowed amount</a> .	
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>	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> 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	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> required for all hospital admissions. (Out-of-Network: \$500 penalty if <a href="#">preauthorization</a> is not obtained.)

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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 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, 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> required for all hospital admissions. (Out-of-Network: \$500 penalty if <a href="#">preauthorization</a> is not obtained.)
	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>	<a href="#">Preauthorization</a> required after 20 days.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required after 20 visit for occupational therapy, physical therapy and speech therapy. 36 visit maximum for cardiac therapy
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required after 20 visit for occupational therapy, physical therapy and speech therapy.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Network</a> and <a href="#">Out-of-Network</a> : 100 days per person per benefit period.
	<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
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 <a href="#">medically necessary</a> )       | • Dental Care (Adult/Child) | • Private Duty Nursing           |
| • Contraceptives (unless <a href="#">medically necessary</a> ) | • Infertility Treatment     | • Routine eye care (Adult/Child) |
| • Cosmetic Surgery   | • Long-Term Care            | • 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                   | • Hearing Aids (up to age 19)                        |
| • Bariatric Surgery             | • Non-emergency care when traveling outside 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. 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 1-855-793-6931

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, kwijigo 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](#) \$6,000
- [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
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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
<b>The total Peg would pay is</b>	<b>\$6,910</b>

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

- The [plan's](#) overall [deductible](#) \$6,000
- [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
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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
<b>The total Joe would pay is</b>	<b>\$2,800</b>

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

- The [plan's](#) overall [deductible](#) \$6,000
- [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
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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
<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.