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**: $3,000/individual or $6,000/family (medical, prescription and mental health combined) **Out-of-network**: $9,000/individual or $18,000/family (medical, prescription and mental health combined)	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. See the Common Medical Events chart on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. **In-network** preventive care services are not subject to a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. A copayment or coinsurance may apply.
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**: $3,000/individual or $6,000/family (medical, prescription and mental health combined) **Out-of-network**: $14,500/individual or $34,500/family (medical, prescription and mental health combined)	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?	Penalties, premiums, balance billing charges 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.umr.com or call 1-800-826-9781 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	20% coinsurance	If a separate facility charge is billed, the hospital facility fee benefits will apply.
	Specialist visit	No charge	20% coinsurance	If a separate facility charge is billed, the hospital facility fee benefits will apply.
	Preventive care/Screening/ immunization	No charge Deductible does not apply.	20% coinsurance	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)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-888-241-7123.	Generic drugs	Retail: No charge Mail: No charge	Same as Network benefit	Covers up to a 30-day supply (retail pharmacy); 31-90-day supply through Benecard Central Fill mail order pharmacy. Some medications require preauthorization or step therapy program adherence. Specialty Drugs 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 copay 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 deductible/out-of-pocket maximum.
	Preferred brand drugs			
	Non-preferred brand drugs			

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)	
				Concordia Plans has arranged for Payer Matrix to assist you in obtaining financial assistance for **specialty drugs**. 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 **plan** design (i.e. applicable **deductible** and **copayment** 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 **appeal**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% **coinsurance**	None
	Physician/surgeon fees	No charge	20% **coinsurance**	None
If you need immediate medical attention	**Emergency room care**	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	If **medically necessary**
	Urgent care	No charge	20% **coinsurance**	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)	No charge	20% **coinsurance**	**Preauthorization** required for all hospital admissions. (Out-of-Network: $500 penalty if **preauthorization** is not obtained.)
	Physician/surgeon fees	No charge	20% **coinsurance**	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% **coinsurance**	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	No charge	20% **coinsurance**	**Preauthorization** required for all hospital admissions. (Out-of-Network: $500 penalty if **preauthorization** is not obtained.)
If you are pregnant	Office visits	No charge **Deductible** does not apply for prenatal visits.	20% **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)	
	Childbirth/delivery professional services	No charge	20% coinsurance	None
	Childbirth/delivery facility services	No charge	20% 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	No charge	20% coinsurance	None
	Rehabilitation services	No charge	20% coinsurance	None
	Habilitation services	No charge	20% coinsurance	None
	Skilled nursing care	No charge	20% coinsurance	100 days/calendar year covered.
	Durable medical equipment	No charge	20% coinsurance	Rental or purchase available dependent upon cost and duration. A preauthorization may apply for certain equipment.
	Hospice services	No charge	20% coinsurance	None
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 exams/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.)

- Abortion (unless medically necessary)
- Contraceptives (unless medically necessary)
- Cosmetic Surgery
- Experimental & Investigational Procedures
- Infertility Treatment
- Long-Term Care
- Routine Foot Care (except for certain medical conditions)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (must be medically necessary, such as for chronic pain management or the prevention or treatment of nausea associated with surgery, chemotherapy, or pregnancy)
- Bariatric Surgery (preauthorization required)
- Chiropractic Care (limited to 26 visits/plan year)
- Dental Care (adult)
- Hearing Aids (cochlear and BAHA implants are covered; other aids available only for children under age 19)
- Non-Emergency Care Traveling Outside U.S. (in-network benefits apply)
- Private Duty Nursing (requirements and restrictions apply to service and service provider)
- Routine Eye Care (adult)

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, kwiijigo 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	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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.