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 *www.healthcare.gov/sbc-glossary* or by calling 1-888-927-7526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-network**: $500/individual or $1,000/family **Out-of-network**: $1,000/individual or $2,000/family	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** and primary 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**: $3,500/individual or $7,000/family **Out-of-network**: $8,000/individual or $16,000/family	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, **copayments**, **premiums**, **balance billing** charges, **prescription drugs**, 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.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	$25 **copay**/visit **Deductible** does not apply.	$50 **copay**/visit **Deductible** does not apply.	None
	Specialist visit	$25 **copay**/visit **Deductible** does not apply.	$50 **copay**/visit **Deductible** does not apply.	None
	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
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: $10 **copay** /prescription **Deductible** does not apply. Mail: $20 **copay** /prescription **Deductible** does not apply.	Retail: $10 **copay**/prescription plus charge above **allowed amount** **Deductible** does not apply.	Covers up to a 30-day supply (retail pharmacy); 31 to 90-day supply (through Express Scripts mail order pharmacy or Walgreens only). Some medications require prior authorization 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.
	Preferred brand drugs	Retail: $25 **copay**/prescription **Deductible** does not apply. Mail: $50 **copay**/prescription **Deductible** does not apply.	$25 **copay** /prescription plus charge above **allowed amount** **Deductible** does not apply.	
	Non-preferred brand drugs	Retail: $50 **copay**/prescription **Deductible** does not apply. Mail: $100 **copay**/prescription **Deductible** does not apply.	Retail: $50 **copay** plus charge above **allowed amount** **Deductible** does not apply.	
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	$100 **copay**/visit **Deductible** does not apply.	$100 **copay**/visit **Deductible** does not apply.	**Copay** waived if admitted within 24 hours.
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	None
	Urgent care	$25 **copay**/visit **Deductible** does not apply.	$50 **copay**/visit **Deductible** does not apply.	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 have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	Hospital certification required for hospital admissions to an **out-of-network provider**, otherwise $500 penalty applied.
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 **copay**/visit **Deductible** does not apply.	$50 **copay**/visit **Deductible** does not apply.	No charge for laboratory tests, psychological testing, or other services.
	Inpatient services	No charge **Deductible** does not apply.	No charge **Deductible** does not apply.	Hospital certification required for hospital admissions to an **out-of-network provider**, otherwise $500 penalty applied.
If you are pregnant	Office visits	$25 **copay**/pregnancy **Deductible** does not apply.	$50 **copay**/pregnancy **Deductible** does not apply.	None
	Childbirth/delivery professional services	No additional charge **Deductible** does not apply.	No additional charge **Deductible** does not apply.	Physician's charges for prenatal/postnatal care and delivery covered by one **copay** per pregnancy. Other services: **deductible**/**coinsurance** apply.
	Childbirth/delivery facility services	20% **coinsurance**	40% **coinsurance**	Hospital certification required for hospital admissions to an **out-of-network provider**, otherwise $500 penalty applied.
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.
	Hospice services	20% **coinsurance**	40% **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 every calendar year. Frames limited to VSP Pediatric Exchange (or any other collection up to $150); otherwise, charges may apply.
	Children's dental check-up	No charge **Deductible** does not apply.	10% **coinsurance** **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.)

- 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 through Blue Cross and Blue Shield of Minnesota)*
- Chiropractic Care *(limited to 26 visits/**plan** year with a limitation to the type of services a chiropractor can perform)*
- *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**

If you don't have **Minimum Essential Coverage** for a month, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$500
Specialist *copayment*	$25
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	$12,738

In this example, Peg would pay:

Cost sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,380
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,030

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

The plan's overall deductible	$500
Specialist copayment	$25
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	$7,420

In this example, Joe would pay:

Cost sharing	
Deductibles	$500
Copayments	$835
Coinsurance	$272
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,662

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

The plan's overall deductible	$500
Specialist copayment	$25
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	$1,955

In this example, Mia would pay:

Cost sharing	
Deductibles	$500
Copayments	$150
Coinsurance	$115
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$765

The plan would be responsible for the other costs of these EXAMPLE covered services.