




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](http://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 <a href="#">deductible</a> ?	<b>In-network:</b> \$500/individual or \$1,000/family (medical and mental health combined) <b>Out-of-network:</b> \$1,000/individual or \$2,000/family (medical and mental health combined)	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <b>In-network preventive care</b> services are not subject to a <b>deductible</b> .	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. A <b>copayment</b> or <b>coinsurance</b> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-network:</b> \$2,000/individual or \$4,000/family (medical, prescription and mental health combined) <b>Out-of-network:</b> \$4,000/individual or \$8,000/family (medical, prescription and mental health combined)	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <b>premiums</b> , <b>balance billing</b> charges and health care this <b>plan</b> doesn't cover	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bluecrossmn.com/Concordia">www.bluecrossmn.com/Concordia</a> or call 1-800-793-6922 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-network provider</u> (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 <b>copay</b> /visit <b>Deductible</b> does not apply.	\$40 <b>copay</b> /visit <b>Deductible</b> does not apply.	None
	<a href="#">Specialist</a> visit	\$40 <b>copay</b> /visit <b>Deductible</b> does not apply.	\$80 <b>copay</b> /visit <b>Deductible</b> does not apply.	None
	<a href="#">Preventive care/Screening/immunization</a>	No charge <b>Deductible</b> does not apply.	40% <b>coinsurance</b>	For a list of 100% paid <b>preventive services</b> , visit <a href="https://ConcordiaPlans.org/system/user_files/Documents/VM00297.pdf">https://ConcordiaPlans.org/system/user_files/Documents/VM00297.pdf</a>  You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
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	Retail: \$15 <b>copay</b> /prescription <b>Deductible</b> does not apply.  Mail: \$30 <b>copay</b> /prescription <b>Deductible</b> does not apply.	Retail: \$15 <b>copay</b> /prescription plus charges above <b>allowed amount</b> <b>Deductible</b> 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. <b>Specialty Drugs</b> 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: \$30 <b>copay</b> /prescription <b>Deductible</b> does not apply.  Mail: \$60 <b>copay</b> /prescription <b>Deductible</b> does not apply.	Retail: \$30 <b>copay</b> /prescription plus charges above <b>allowed amount</b> <b>Deductible</b> does not apply.	
	Non-preferred brand drugs	Retail: \$60 <b>copay</b> /prescription <b>Deductible</b> does not apply.  Mail: \$120 <b>copay</b> /prescription <b>Deductible</b> does not apply.	Retail: \$60 <b>copay</b> plus charges above <b>allowed amount</b> <b>Deductible</b> does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	Physician/surgeon fees	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	<a href="#">Emergency room care</a>	\$150 <b>copay</b> /visit <b>Deductible</b> does not apply.	\$150 <b>copay</b> /visit <b>Deductible</b> does not apply.	<b>Copay</b> 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)	
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	20% <b>coinsurance</b>	20% <b>coinsurance</b>	If <b>medically necessary</b> .
	<a href="#">Urgent care</a>	\$50 <b>copay</b> /visit <b>Deductible</b> does not apply.	\$100 <b>copay</b> /visit <b>Deductible</b> does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Hospital certification required for all hospital admissions. ( <b>Out-of-Network: \$500 penalty if pre-certification is not obtained</b> )
	Physician/surgeon fees	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <b>copay</b> /visit <b>Deductible</b> does not apply.	\$40 <b>copay</b> /visit <b>Deductible</b> does not apply.	Laboratory tests, psychological testing, and other services subject to <b>deductible</b> and <b>coinsurance</b> .
	Inpatient services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Hospital certification required for all hospital admissions. ( <b>Out-of-Network: \$500 penalty if pre-certification is not obtained</b> )
If you are pregnant	Office visits	Prenatal: No charge <b>Deductible</b> does not apply. Postnatal: \$20 <b>copay</b> /visit <b>Deductible</b> does not apply.	Prenatal: 40% <b>coinsurance</b> Postnatal: \$40 <b>copay</b> /visit <b>Deductible</b> does not apply.	Physician's charges for prenatal care covered at 100% per pregnancy for <b>network providers</b> only.
	Childbirth/delivery professional services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	Childbirth/delivery facility services	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Hospital certification required for all hospital admissions. ( <b>Out-of-Network: \$500 penalty if pre-certification is not obtained</b> )
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	<a href="#">Rehabilitation services</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	<a href="#">Habilitation services</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
	<a href="#">Skilled nursing care</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Up to 100 days/calendar year.
	<a href="#">Durable medical equipment</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Rental or purchase available dependent upon cost and duration.
	<a href="#">Hospice services</a>	20% <b>coinsurance</b>	40% <b>coinsurance</b>	None
If your child needs dental or eye care	Children's eye exam	No charge <b>Deductible</b> does not apply.	50% <b>coinsurance</b> <b>Deductible</b> does not apply.	One exam/calendar year.
	Children's glasses	No charge <b>Deductible</b> does not apply.	50% <b>coinsurance</b> <b>Deductible</b> does not apply.	Lenses and/or frames covered once every calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-network provider</u> (You will pay the most)	
				Frames limited to VSP Pediatric Exchange (or any other collection up to \$150); otherwise, charges may apply.
	Children's dental check-up	No charge <b>Deductible</b> does not apply.	No charge <b>Deductible</b> 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](#).)

- 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](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**

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, 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](#) \$500
- [Specialist copayment](#) \$40
- 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	\$12,755
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,660</b>

**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](#) \$40
- 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	\$7,465
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,055
<u>Coinsurance</u>	\$272
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,883</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- 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	\$1,925
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$230
<u>Coinsurance</u>	\$115
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$845</b>

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