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**: $3,000/individual or $6,000/family (medical, prescription and mental health combined) Out-of-**Network**: $6,000/individual or $12,000/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**.
Are there services covered before you meet your deductible?	Yes. In-**network** **preventive care** services and out-of-**network** immunizations through age 4 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. For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at ***https://www.healthcare.gov/coverage/preventive-care-benefits/***.
Are there other deductibles for specific services?	Yes. $200 external prosthetic appliance annual **deductible**. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-**Network**: $5,500/individual or $11,000/family (medical, prescription and mental health combined) Out-of-**Network**: $11,000/individual or $22,000/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?	**Premiums**, **balance billing** charges, **copayments** for certain services 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	15% **coinsurance** /visit	35% **coinsurance** /visit	None
	Specialist visit	15% **coinsurance** /visit	35% **coinsurance** /visit	None
	Preventive care/screening/ immunization	No charge **Deductible** does not apply.	Not covered/visit 35% coinsurance/**screening** Not covered/immunization (after age 4)	No charge for out-of-**network** immunizations for children through age 4. You may have to pay for services that are not preventive. Ask your **provider** if the services rendered are preventive. Then check what your **plan** will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	5% **coinsurance** for lab at preferred independent lab (Lab Corp and Quest) 15% **coinsurance** for x-ray/lab through outpatient, lab in physician's office or at non-preferred independent lab	35% **coinsurance** /x-ray or lab (outpatient) or lab (physician's office)	None
	Imaging (CT/PET scans, MRIs)	15% **coinsurance**	35% **coinsurance**	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at ***www.ConcordiaPlans.org***	Generic drugs	Preventive Drugs: $0 (retail and mail) **Deductible** does not apply. Retail: 20% **coinsurance** ($75 max/prescription) Mail: 20% **coinsurance** ($150 max/prescription)	Preventive: $0 plus charges above **allowed amount** **Deductible** does not apply. Retail: 20% **coinsurance** ($75 max/prescription) plus charges above **allowed amount**	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			
	Non-preferred brand drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% **coinsurance**	35% **coinsurance**	None
	Physician/surgeon fees	15% **coinsurance**	35% **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 immediate medical attention	Emergency room care	Life Threatening ER Visit: 15% **coinsurance** Non-Life Threatening ER Visit: 40% **coinsurance**	Life Threatening ER Visit: 15% **coinsurance** Non-Life Threatening ER Visit: 40% **coinsurance**	None
	Emergency medical transportation	15% **coinsurance**	15% **coinsurance**	If **medically necessary**.
	Urgent care	15% **coinsurance**	35% **coinsurance**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% **coinsurance**	35% **coinsurance**	None
	Physician/surgeon fees	15% **coinsurance**	35% **coinsurance**	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% **coinsurance**	35% **coinsurance**	None
	Inpatient services	15% **coinsurance**	35% **coinsurance**	None
If you are pregnant	Office visits	No charge	35% **coinsurance**	None
	Childbirth/delivery professional services	15% **coinsurance**	35% **coinsurance**	None
	Childbirth/delivery facility services	15% **coinsurance**	35% **coinsurance**	None
If you need help recovering or have other special health needs	Home health care	15% **coinsurance**	35% **coinsurance**	60-day maximum/**plan** year (16-hour day)
	Rehabilitation services	15% **coinsurance**	35% **coinsurance**	Pulmonary rehabilitation and Cognitive, Physical, Speech, and Occupational therapies – 40-day maximum (combined); Cardiac rehabilitation – 36 day maximum
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	15% **coinsurance**	35% **coinsurance**	60-day maximum/**plan** year
	Durable medical equipment	15% **coinsurance**	35% **coinsurance**	$200 annual **deductible** for external prosthetic appliances.
	Hospice services	15% **coinsurance**	35% **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 every 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.	50% **coinsurance** **Deductible** does not apply.	Two exams per 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	• **Habilitation services**	• Non-Emergency Care Traveling Outside U.S.
• Accupuncture	• Hearing Aids	• Routine Foot Care
• Bariatric Surgery	• Infertility Treatment	• Weight Loss Programs
• Cosmetic Surgery	• Long-Term Care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (limited to 26 visits per **plan** year with a limitation to the type of services a chiropractor can perform)	• Dental Care (children)	• Private Duty Nursing (requirements and restrictions apply to service and service **provider**)
• Dental Care (adult)	• Eye Care (children)	• 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

The Affordable Care Act requires most people to have health care coverage that qualifies as "**Minimum Essential Coverage**." This **plan** or policy does provide **Minimum Essential Coverage**.

Does this plan meet the Minimum Value Standards? Yes

The Affordable Care Act establishes a **Minimum Value Standard** of benefits of a health **plan**. The **Minimum Value Standard** is 60% (actuarial value). This health coverage does meet the **Minimum Value Standard** for the benefits it provides.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$12,800

In this example, Peg would pay:

Cost sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$4,410

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	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$7,400

In this example, Joe would pay:

Cost sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$3,800

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

The plan's overall deductible	$3,000
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$1,900

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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