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 call 1-888-927-7526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-network:** $1,200/individual or $2,400/family **Out-of-network:** N/A	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. 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. Well-child care, prenatal care, network Preventive care services, physician office visits, home health, and durable medical equipment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But 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?	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:** N/A (medical, mental health and pharmacy)	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 limits has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties and health care this plan doesn't cover. Plus, certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out–of–pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) won't be applied to your out-of-pocket maximums.	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.myCigna.com or call **1-866-302-7578** for a list of network providers.	This plan uses a provider network. Out-of-network services are not covered. Check with your network provider before you receive services so that they do not use an out-of-network provider for any services (such as lab work).
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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay Deductible does not apply	Not covered	None
	Specialist visit	$60 copay Deductible does not apply	Not covered	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Covered under the Physician's Office, Emergency Room, Urgent Care or Outpatient Benefits (based on place of service).	Not covered	None
	Imaging (CT/PET scans, MRIs)	Covered under the Physician's Office, Emergency Room, Urgent Care or Outpatient Benefits (based on place of service).	Not covered	
If you need drugs to treat your illness or condition.	Generic drugs	$10 copay: Retail (30-day) $25 copay: 31-90 days Deductible does not apply	Not covered	Up to a 30-day supply (retail); 31 to 90-day supply (home delivery or select network 90-day retail pharmacy).

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	
More information about prescription drug coverage is available by calling 1-888-927-7526	Preferred Brand	30% coinsurance ($25 minimum, $75 maximum): Retail (30-day) 30% coinsurance ($62.50 minimum, $187.50 maximum) 31-90 days Deductible does not apply For insulin drugs only: 30-day supply: $25 copay 60-daysupply: $50 copay 90-daysupply: $75 copay	Not covered	Coverage for certain maintenance medications limited to 90-day prescription fills, otherwise after two 30-day fills of the same prescription at a retail pharmacy, your cost will be 100% of the cost of the prescription. Up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. 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 or out-of-pocket maximum.
	Non-preferred Brand	40% coinsurance ($50 minimum, $100 maximum): Retail (30-day) 40% coinsurance ($125 minimum, $250 maximum) 31-90 days Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	No charge Deductible does not apply.	Not covered	None
If you need immediate medical attention	Emergency room care	$200 visit copay	$200 visit copay	Per visit ER copay waived if admitted within 24 hours from Emergency room visit. Out of network benefits only apply if services received are outside of the KelseyCare network.

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	
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	If medically necessary. Out of network benefits only apply if services received are outside of the KelseyCare network.
	Urgent care	$60 office visit copay Deductible does not apply	$60 office visit copay Deductible does not apply	Out of network benefits only apply if services received are outside of the KelseyCare network. Urgent Care copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	No charge Deductible does not apply.	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay for office visit Deductible does not apply No charge for other outpatient services Deductible does not apply.	Not covered	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits*	$35 copay/visit for primary care or $60 copay/visit for specialist to determine pregnancy. All subsequent visits covered 100%. Deductible does not apply.	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Processed as a global maternity service which includes pre-natal, post-natal and the delivery service.
	Childbirth/delivery professional services*	No charge Deductible does not apply.	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	

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 need help recovering or have other special health needs	Home health care	No charge Deductible does not apply.	Not covered	Preauthorization required. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$35 copay/visit for primary care $60 copay/visit for specialist Deductible does not apply.	Not covered	Occupational, physical and speech therapy each have a 40-visit maximum. 26 visits for chiropractic. 36 visits for cardiac therapy.
	Habilitation services	$35 copay/visit for primary care $60 copay/visit for specialist Deductible does not apply.	Not covered	Occupational, physical and speech therapy each have a 40-visit maximum. Must be medically necessary.
	Skilled nursing care	20% coinsurance	Not covered	60 days per person per benefit period.
	Durable medical equipment	No charge Deductible does not apply.	Not covered	A preauthorization may apply for certain equipment.
	Hospice services	Inpatient: 20% coinsurance Outpatient: No charge; Deductible does not apply.	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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 (except as specified in Plan benefits)
- Dental Care (Adult/Child)
- Habilitation (unless medically necessary)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (unless medically necessary)
- Routine eye care (Adult/Child)
- 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
- Bariatric surgery
- Hearing Aids (up to age 19)
- 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*. 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 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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*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	$1,200
Specialist copayment	$60
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$60
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,320**

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

The plan's overall deductible	$1,200
Specialist copayment	$60
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$1,200
Specialist copayment	$60
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$600
Coinsurance	$00
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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