# Concordia Health Plan 2021
## Whole Health 2000 At-a-Glance
(Reflects Member’s Responsibility)

<table>
<thead>
<tr>
<th>Medical and Mental Health Benefits — Administered by Kaiser Permanente</th>
<th>Network Cost</th>
<th>Non-Network Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Only Deductible Maximum</td>
<td>$2,000</td>
<td>Not covered</td>
</tr>
<tr>
<td>Family Deductible Maximum*</td>
<td>$4,000</td>
<td>Not covered</td>
</tr>
<tr>
<td>Self Only Out-of-Pocket Maximum</td>
<td>$3,000</td>
<td>Not covered</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum*</td>
<td>$6,000</td>
<td>Not covered</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>N/A</td>
<td>Not covered</td>
</tr>
<tr>
<td>Family Coinsurance Maximum</td>
<td>N/A</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visit: Primary</td>
<td>$30 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visit: Specialist</td>
<td>$30 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well Child Care (under age 6)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$10 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>$10 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>$50 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient and Outpatient Hospitalization</td>
<td>$250 copay/admission after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Individual &amp; Group Therapy</td>
<td>Individual: $30 copay/visit after deductible Group: $15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$100 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>For an ER visit out of network, once your condition is stable, call Kaiser Permanente to let them know you received emergency care or were admitted to a hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30 copay/visit after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drug Benefits — Administered by Kaiser Permanente</th>
<th>Retail Pharmacy Short-Term Medication</th>
<th>Mail Order Pharmacy Long-Term Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>See copay structure below</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>KP Pharmacy or Mail Order Pharmacy 30-Day Supply: $10 copay after deductible Community Network Pharmacy 30-Day Supply: $20 copay after deductible</td>
<td>30-Day Supply: $10 copay after deductible 31 to 90-Day Supply: $20 copay after deductible</td>
</tr>
<tr>
<td>Brand-name Formulary</td>
<td>KP Pharmacy or Mail Order Pharmacy 30-Day Supply: $30 copay after deductible Community Network Pharmacy 30-Day Supply: $40 copay after deductible</td>
<td>30-Day Supply: $30 copay after deductible 31 to 90-Day Supply: $60 copay after deductible</td>
</tr>
<tr>
<td>Brand-name Non-Formulary</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other CHP Benefits and Discounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
</tr>
</tbody>
</table>

*If coverage other than Self Only is elected, the family deductible must be satisfied before coinsurance applies. This is called a non-embedded deductible. The out-of-pocket maximum is also non-embedded.*

**Legal Disclaimer**

This document is a brief outline of benefits provided by the Concordia Health Plan option referenced above. While every effort has been made to provide accurate information, please refer to the CHP official plan document and the appropriate CHP Schedule for more detailed information.

CHP_AAG_KAISER_9203_0920