Concordia Health Plan 2022
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>N/A</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visit: Primary</td>
<td>$30</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visit: Specialist</td>
<td>$30</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</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>$10</td>
<td>Not covered</td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>$50</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$250</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Individual &amp; Group Therapy</td>
<td>Individual: $30</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Group: $15</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$100</td>
<td>Not covered</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Prescription Drug Benefits — Administered by Kaiser Permanente**

<table>
<thead>
<tr>
<th>Preventive Drug Benefits — Retail Pharmacy</th>
<th>See copay structure below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>KP Pharmacy or Mail Order Pharmacy</td>
</tr>
<tr>
<td>30-Day Supply: $10 copay after deductible</td>
<td>30-Day Supply: $10 copay after deductible</td>
</tr>
<tr>
<td>Community Network Pharmacy</td>
<td>31 to 90-Day Supply: $20 copay after deductible</td>
</tr>
<tr>
<td>30-Day Supply: $20 copay after deductible</td>
<td>30-Day Supply: $30 copay after deductible</td>
</tr>
<tr>
<td>Brand-name Formulary</td>
<td>KP Pharmacy or Mail Order Pharmacy</td>
</tr>
<tr>
<td>30-Day Supply: $30 copay after deductible</td>
<td>31 to 90-Day Supply: $60 copay after deductible</td>
</tr>
<tr>
<td>Community Network Pharmacy</td>
<td>30-Day Supply: $40 copay after deductible</td>
</tr>
<tr>
<td>Brand-name Non-Formulary</td>
<td>N/A</td>
</tr>
<tr>
<td>Other CHP Benefits and Discounts</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>TruHearing</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Cigna Behavioral Health</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.