
 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 <https://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: \$600/individual or \$1,200/family Out-of-network: \$1,200/individual or \$2,400/family (medical 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. 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 and Network Preventive care services 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: \$3,000/individual or \$6,000/family Out-of-network: \$6,000/individual or \$12,000/family (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. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits . The cost of these drugs (if 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 . 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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 office visit copay Deductible does not apply	\$70 office visit copay Deductible does not apply	None
	Specialist visit	\$60 office visit copay Deductible does not apply	\$120 office visit copay Deductible does not apply	None
	Preventive care/screening/ Immunization	No charge Deductible does not apply.	Not covered	No charge for out-of-network immunizations through age 4. 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)	20% coinsurance 10% coinsurance for a Preferred Independent lab and deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition.	Generic drugs	\$10 copay : 30 days \$25 copay : 31-90 days Deductible does not apply	No coverage	Up to a 30-day supply (retail); 31-90-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	
<p>More information about prescription drug coverage is available by calling 1-888-927-7526</p>	Preferred Brand	<p>30% coinsurance (\$25 minimum, \$75 maximum): 30 days 30% coinsurance (\$62.50 minimum, \$187.50 maximum) 31-90 days</p> <p>For insulin drugs only: 30-day supply: \$25 copay 60-day supply: \$50 copay 90-day supply: \$75 copay</p> <p>Deductible does not apply</p>	No coverage	<p>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: preauthorization, step therapy, quantity limits.</p> <p>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.</p> <p>Certain specialty medications are eligible for the SaveOnSP program. Members who are taking eligible SaveOnSP medications will be requested to enroll in the program. If a member chooses not to participate in SaveOnSP, they will pay a higher cost share.</p> <p>For Specialty Drugs, see “Important Questions” regarding the plan’s out-of-pocket limit.</p>
	Non-preferred Brand	<p>40% coinsurance (\$50 minimum, \$100 maximum): 30 days 40% coinsurance (\$125 minimum, \$250 maximum) 31-90 days Deductible does not apply</p>	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None

For more information about limitations and exceptions, call 1-888-927-7526 or visit us at www.ConcordiaPlans.org

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	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$200 copay then deductible	\$200 copay then deductible	Per visit ER copay waived if admitted within 24 hours from Emergency room visit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	If medically necessary
	Urgent care	\$60 office visit copay Deductible does not apply	\$60 office visit copay Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for all hospital admissions.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 Primary office visit copay and Deductible does not apply. 20% coinsurance other outpatient services.	\$70 Primary office visit copay and Deductible does not apply. 40% coinsurance other outpatient services.	Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for all hospital admissions.
If you are pregnant	Office visits*	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, a coinsurance 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. Preauthorization required for all hospital admissions.
	Childbirth/delivery professional services*	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)

For more information about limitations and exceptions, call 1-888-927-7526 or visit us at www.ConcordiaPlans.org

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	
	Rehabilitation services	\$35 copay /visit for primary care \$60 copay /visit for specialist . Deductible does not apply.	40% coinsurance	Occupational, physical and speech therapy each have a 40-visit maximum. 36 visits for cardiac therapy.
	Habilitation services	\$35 copay /visit for primary care \$60 copay /visit for specialist . Deductible does not apply.	40% coinsurance	Occupational, physical and speech therapy each have a 40-visit maximum.
	Skilled nursing care	20% coinsurance	40% coinsurance	In-network and out-of-network: 60 days per person per benefit period.
	Durable medical equipment	20% coinsurance	40% coinsurance	A preauthorization may apply for certain equipment.
	Hospice services	20% coinsurance	40% coinsurance	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](#).)

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|---|---|--|
| <ul style="list-style-type: none"> • Abortion (unless medically necessary) • Contraceptives (unless medically necessary) • Cosmetic Surgery • Dental Care (Adult/Child) | <ul style="list-style-type: none"> • Infertility Treatment • Long-Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private Duty Nursing (unless medically necessary) • Routine eye care (Adult/Child) • Routine Foot Care • Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic Care (26 visits) • Hearing Aids (up to age 19) |
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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, kwijigo 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](#) \$600
- [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$70
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$2,670

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

- The [plan's](#) overall [deductible](#) \$600
- [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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$900
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$1,760

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

- The [plan's](#) overall [deductible](#) \$600
- [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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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