




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 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-network: \$2,000/individual or \$4,000/family (medical, prescription drugs and mental health combined) Out-of-network: Not covered/individual or family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Network Preventive care services, immunizations, home health care, durable medical equipment, breast feeding equipment/supplies and lab services are covered before you meet your deductible.</p>	<p>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/</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>In-network: \$4,000/individual or \$8,000 /family (medical, prescription drugs and mental health combined) Out-of-network: Not covered</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, prescription drug copays, balance billing charges, penalties, health care this plan doesn't cover and services received from out-of-network providers unless otherwise noted or a preauthorization is received by Cigna. 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.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.myCigna.com or call 1-866-302-7578) for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>Yes. Approval from primary care physician is required to see a specialist.</p>	<p>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. Referral to participating OB/GYN is not required for well-woman exam.</p>

 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	\$30 copay /visit Deductible does not apply.	Not covered	None
	Specialist visit	\$40 copay /visit 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)	No charge. Deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	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 drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-888-927-7526	Generic drugs	Retail: \$15 copay /prescription Mail: \$35 copay /prescription Deductible does not apply.	Not covered	Covers up to a 30 days supply (retail pharmacy); up to a 90 days supply (mail order). Some medications require preauthorization or step therapy program adherence. 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. For Specialty Drugs , see “Important Questions” regarding the plan’s out-of-pocket limit .
	Preferred brand drugs	Retail: \$35 copay /prescription Mail: \$70 copay /prescription For insulin drugs only: 30 days supply: \$25 copay 60 days supply: \$50 copay 90 days supply: \$70 copay Deductible does not apply.	Not covered	
	Non-preferred brand drugs	Retail: \$55 copay /prescription Mail: \$110 copay /prescription Deductible does not apply.	Not covered	
Specialty Drugs	Mail 30 days supply: Generic: \$11 copay /prescription Perferred: \$23 copay /prescription Non-Perferred: \$36 copay /prescription Deductible does not apply.	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge Deductible does not apply.	Not covered	None
If you need immediate medical attention	Emergency room care	\$150 copay /visit Deductible does not apply.	\$150 copay /visit Deductible does not apply.	Copay waived if admitted within 24 hours.

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)	
	Emergency medical transportation	No charge. Deductible does not apply.	No charge Deductible does not apply.	If medically necessary .
	Urgent care	\$100 copay /visit Deductible does not apply.	\$100 copay /visit Deductible does not apply.	Copay waived if immediately admitted to hospital from visit
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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	\$30 copay /visit Deductible does not apply.	Not covered	One copay applies/Intensive Outpatient Care program; no charge for laboratory tests, psychological testing, or other services. Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	\$30 copay /visit if primary care \$40 copay /visit if specialist Deductible does not apply.	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay /pregnancy.
	Childbirth/delivery professional services	No additional charge Deductible does not apply.	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay /pregnancy.
	Childbirth/delivery facility services	No charge	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay /pregnancy.
If you need help recovering or have other special health needs	Home health care	No charge Deductible does not apply.	Not covered	16-hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	\$30 copay /visit if primary care \$40 copay /visit if specialist Deductible does not apply.	Not covered	None
	Habilitation services	\$30 copay /visit if primary care \$40 copay /visit if specialist	Not covered	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)	
		<u>Deductible</u> does not apply.		
	<u>Skilled nursing care</u>	No charge	Not covered	Coverage is limited to 100 days annual maximum.
	<u>Durable medical equipment</u>	No charge <u>Deductible</u> does not apply.	Not covered	A <u>preauthorization</u> may apply for certain equipment.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Abortion (unless <u>medically necessary</u>) Contraceptives (unless <u>medically necessary</u>) Cosmetic Surgery (except as specified in Plan benefits) Dental Care (Adult/Child) 	<ul style="list-style-type: none"> Habilitation (unless <u>medically necessary</u>) Infertility Treatment Long-Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private Duty Nursing 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 <u>plan</u> document.)	
<ul style="list-style-type: none"> Acupuncture Bariatric surgery 	<ul style="list-style-type: none"> Hearing Aids (up to age 19) Chiropractic Care (20 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 the 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 1-800-793-6922.

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, kwijigo 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 pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

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:

Cost sharing	
Deductibles	\$2,000
Copayments	\$50
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$2,150

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

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:

Cost sharing	
Deductibles	\$900
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$0
■ Other coinsurance	0%

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:

Cost sharing	
Deductibles	\$400
Copayments	\$400
Coinsurance	\$0
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.