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:
What is the overall deductible?	**In-network**: $0/individual or family **Out-of-network**: Not covered/individual or family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	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**: $2,500/individual or $7,500 /family (medical and mental health combined) **Out-of-network**: Not covered	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.
What is not included in the out-of-pocket limit?	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.	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?	Yes. Approval from **primary care physician** is required to see a **specialist**.	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.

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	Not covered	None
	Specialist visit	$40 **copay**/visit	Not covered	None
	Preventive care/**Screening**/ immunization	No charge	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	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	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	Not covered	
	Non-preferred brand drugs	Retail: $55 copay/prescription Mail: $110 copay/prescription	Not covered	
	Specialty Drugs	Mail 30 days supply: Generic: $11 copay/prescription Perferred: $23 copay/prescription Non-Perferred: $36 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted within 24 hours.
	Emergency medical transportation	No charge	No charge	If medically necessary.
	Urgent care	$90 copay/visit	$90 copay/visit	Copay waived if immediately admitted to hospital from visit

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 have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission or facility visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	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	$500 copay/admission	Not covered	None
If you are pregnant	Office visits	Primary care provider: $30 copay Specialist: $40 copay	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay/pregnancy.
	Childbirth/delivery professional services	No additional charge	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay/pregnancy.
	Childbirth/delivery facility services	$500 copay/admission	Not covered	Physician's charges for delivery covered under one prenatal/postnatal copay/pregnancy; if baby stays in hospital after mother is discharged, separate $500 copay may apply.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	16-hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	Primary care provider: $30 copay Specialist: $40 copay	Not covered	None
	Habilitation services	Primary care provider: $30 copay Specialist: $40 copay	Not covered	None
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days annual maximum.
	Durable medical equipment	No charge	Not covered	A preauthorization may apply for certain equipment.
	Hospice services	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 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 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)
- 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
- 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 (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, kwiijigo 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	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
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**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$700**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
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**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,100**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$500
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**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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