

**Concordia Health Plan 2019
Whole Health 2000 At-A-Glance
(Reflects Member's Responsibility)**

Medical Benefits – Administered by Kaiser Permanente		
	Network Cost	Non-Network Cost
Individual Deductible Maximum	\$2,000	Not covered
Family Deductible Maximum	\$4,000	Not covered
Individual Out-of-Pocket Maximum	\$3,000	Not covered
Family Out-of-Pocket Maximum	\$6,000	Not covered
Coinsurance	N/A	Not covered
Individual Coinsurance Maximum	N/A	N/A
Family Coinsurance Maximum	N/A	N/A
Preventive Care	No charge	Not covered
Office Visit: Primary	\$30 copay/visit after deductible	Not covered
Office Visit: Specialist	\$30 copay/visit after deductible	Not covered
Well Child Care (under age 6)	No charge	Not covered
Laboratory	\$10 copay/visit after deductible	Not covered
Diagnostic Radiology	\$10 copay after deductible	Not covered
Advanced Imaging	\$50 copay/visit after deductible	Not covered
Inpatient and Outpatient Hospitalization	\$250 copay/admission after deductible	Not covered
Emergency Room Visit	\$100 copay/visit after deductible 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.	
Urgent Care	\$30 copay/visit after deductible	\$30 copay/visit after deductible

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

Mental Health/Substance Abuse Benefits – Administered by Kaiser Permanente		
	Network Cost	Non-Network Cost
Individual Deductible Maximum	\$2,000	Not covered
Family Deductible Maximum	\$4,000	Not covered
Coinsurance	N/A	N/A
Outpatient Individual & Group Therapy	Individual: \$30 copay/visit Group: \$15 copay/visit	Not covered
Emergency Room Visit	\$100 copay/visit (waived if admitted)	
Inpatient Care	\$250 copay/admission after deductible	Not covered
Other Covered Expenses	Varies	Not covered

Other CHP Benefits and Discounts	
Hearing Care	HearUSA and Cigna Healthy Rewards
Employee Assistance Program	Cigna Behavioral Health

Legal Disclaimer

This document is a brief outline of benefits provided by the Concordia Health Plan (CHP) 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. Those documents and additional plan information can be found online at ConcordiaPlans.org.