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 *www.healthcare.gov/sbc-glossary* or by calling 1-888-927-7526 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.	You will have to meet the **deductible** before the **plan** pays for any services.
Are there other deductibles for specific services?	Yes. There is a $200 **deductible** for prosthetic or orthopedic devices through **in-network providers**. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	**In-network**: $1,850/individual or $5,550/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, health care this **plan** doesn't cover and services received from **out-of-network providers** unless otherwise noted or preauthorized by Cigna.	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 1-800-Cigna24 (244-6224) 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	$20 **copay**/visit	Not covered	None
	Specialist visit	$30 **copay**/visit	Not covered	None
	Preventive care/Screening/ immunization	**Primary care physician**: $20 **copay**/visit **Specialist**: $30 **copay**/visit	Not covered	For a list of 100% paid **preventive services**, visit ***https://ConcordiaPlans.org/system/user_files/Documents/508230.pdf*** Immunizations covered at 100% if no office visit charge
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
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: $25 **copay** /prescription	Not covered	Covers up to a 30-day supply (retail pharmacy); up to a 90 day supply (Tel-Drug mail order drug program). Some medications require prior authorization or step therapy program adherence. Same **copays** apply to **Specialty Drugs** at retail. After four consecutive fills of the same prescription at a retail pharmacy, your cost will be 50% of cost or the appropriate mail order **copay**, whichever is greater. Exceptions may apply.
	Preferred brand drugs	Retail: $25 **copay** /prescription Mail: $50 **copay** /prescription	Not covered	
	Non-preferred brand drugs	Retail: $50 **copay** /prescription Mail: $100 **copay** /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$430 **copay**/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$120 **copay**/visit	$120 **copay**/visit	**Copay** waived if admitted within 24 hours.
	Emergency medical transportation	No charge	No charge	If **medically necessary**.
	Urgent care	$60 **copay**/visit	$60 **copay**/visit	**Copay** waived if immediately admitted to hospital from visit
If you have a hospital stay	Facility fee (e.g., hospital room)	$430 **copay**/admission or facility visit	Not covered	None
	Physician/surgeon fees	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 mental health, behavioral health, or substance abuse services	Outpatient services	$20 **copay**/visit	Not covered	One **copay** applies/Intensive Outpatient Care program; no charge for laboratory tests, psychological testing, or other services.
	Inpatient services	$430 **copay**/admission	Not covered	None
If you are pregnant	Office visits	**Primary care provider**: $20 **copay**/pregnancy **Specialist**: $30 **copay**/pregnancy	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	$430 **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 $430 **copay** may apply.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	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	Rental or purchase available dependent upon cost and duration. Annual; $200 **deductible** for external prosthetic device
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	50% **coinsurance**	One exam/calendar year.
	Children's glasses	No charge	50% **coinsurance**	Lenses and/or frames covered once every calendar year. Frames limited to VSP Pediatric Exchange (or any other collection up to $150); otherwise, charges may apply.
	Children's dental check-up	No charge	10% **coinsurance**	Two exams/calendar year.

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.)

- Cosmetic Surgery
- Experimental & Investigational Procedures
- Habilitation Services
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Routine Foot Care *(except for certain medical conditions)*
- 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 • Chiropractic Care *(maximum 20 days/calendar year)*	• Dental Care *(adult)* • Hearing Aids *(no charge for exams and supplies for children under age 19, except for physician office visits that are subject to copays; $4,000 maximum benefit/year)*	• Private-Duty Nursing *(requirements and restrictions apply to service and service provider)* • Routine Eye Care *(adult)*

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**

If you don't have **Minimum Essential Coverage** for a month, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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*	$30
Hospital (facility) copayment	$430
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	$12,800

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$510

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	$30
Hospital (facility) copayment	$430
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	$7,400

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$900

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$430
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	$1,900

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$200

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