



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, visit www.choosebind.com/CCSD, MyBind mobile app, www.MyBind.com website or call Bind Help at 1-833-576-6494. 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 1-833-576-6494 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	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 . 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 ?	For network providers : \$3,500 individual / \$7,000 family For out-of-network providers : \$7,000 individual / \$14,000 family	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 , balance billing charges and health care this plan doesn't cover.	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.choosebind.com/CCSD , or call 1-833-576-6494 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*
		In-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	\$15 - \$75 copayment /visit	\$140 copayment /visit	<p>Certain procedures performed in the office may have a higher office visit copayment.</p> <p>Certain conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan. See Section 5: Covered Health Services*.</p> <p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis.</p> <p>You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</p>
	Specialist visit	\$15 - \$75 copayment /visit	\$140 copayment /visit	
	Preventive care/screening/immunization	No charge	\$105 copayment /visit	
If you have a test	Diagnostic test (e.g., x-ray, blood work)	Routine diagnostic test: No charge Non-routine diagnostic test: \$75 - \$400 copayment /visit	Routine diagnostic test: No charge Non-routine diagnostic test: \$240 - \$800 copayment /visit	<p>Higher copayments may apply to certain non-routine diagnostic test.</p> <p>Certain conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan. See Section 5: Covered Health Services*.</p> <p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis.</p> <p>Prior authorization is required for certain imaging tests or there may be no coverage.</p>
	Imaging (CT/PET scans, MRIs)	\$250 - \$1,000 copayment	\$2,000 copayment	

*For more information about limitations and exceptions, see the [plan](#) or policy document at www.choosebind.com/CCSD, (Active Access code: CCSD2021, COBRA Access code: CCSDcobra2021). After you enroll visit the MyBind mobile app or www.MyBind.com website.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.choosebind.com/CCSD.</p>	Tier 1 drugs	<p>30-Day Supply \$5 copayment at Preferred Pharmacies; \$20 copayment at other network pharmacies</p> <p>90-Day Supply \$15 copayment at Preferred Pharmacies or Kroger Mail Order; \$50 copayment at other network pharmacies</p>	Not covered	<p>Certain Tier 1 drugs are available with \$0 copayments, including prescribed generic contraceptives and tobacco cessation medications.</p> <p>To learn more about drug tiers and about copayments for specific drugs, visit www.choosebind.com/CCSD, (Active Access code: CCSD2021, COBRA Access code: CCSDcobra2021), the MyBind mobile app or www.MyBind.com website. Prior authorization is required for certain drugs or there may be no coverage.</p>
	Tier 2 drugs	<p>30-Day Supply \$80 copayment at Preferred Pharmacies and other network pharmacies</p> <p>90-Day Supply \$200 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order</p>	Not covered	
	Tier 3 drugs	<p>30-Day Supply \$150 copayment at Preferred Pharmacies and other network pharmacies</p> <p>90-Day Supply \$375 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order</p>	Not covered	
	Specialty drugs	<p>30-Day Supply Tier 1: \$200 copayment Tier 2: \$300 copayment Tier 3: \$400 copayment</p>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$110 - \$3,400 copayment /visit	\$290 - \$8,000 copayment /visit	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis.</p> <p>Certain conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan. See Section 5: Covered Health Services*.</p> <p>Prior authorization is required for certain outpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	Included in the facility copayment	Included in the facility copayment	
If you need immediate medical attention	Emergency room care	\$750 copayment /visit	\$750 copayment /visit	<p>Copayment is waived if admitted within 24 hours. Out-of-network emergency room care visit copayment applies to the in-network out-of-pocket limit.</p> <p>Out-of-network emergency medical transportation copayment applies to the in-network out-of-pocket limit.</p>
	Emergency medical transportation	\$850 copayment /transport	\$850 copayment /transport	
	Urgent care	\$100 copayment /visit	\$200 copayment /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,150 - \$3,400 copayment /stay	\$3,600 - \$8,000 copayment /stay	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis.</p> <p>Certain conditional coverage tests and treatments must first be activated by you before coverage is effective under the plan. See Section 5: Covered Health Services*.</p> <p>Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	Included in the facility copayment	Included in the facility copayment	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Home/Office: \$15 copayment /visit Outpatient Hospital: \$1,500 copayment /visit	Home/Office: \$140 copayment /visit Outpatient Hospital: \$3,000 copayment /visit	Certain procedures/services in the outpatient setting may have a lower copayment . Prior authorization is required for certain outpatient services or there may be no coverage.
	Inpatient services	\$3,000 copayment /stay	\$6,000 copayment /stay	Certain procedures/services in the inpatient setting may have a lower copayment . Prior authorization is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	\$105 copayment /visit	Cost sharing does not apply to preventive services with network providers . Depending on the type of service, a copayment may apply.
	Childbirth/delivery professional services	Included in the facility copayment	Included in the facility copayment	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	\$1,500 - \$3,500 copayment /stay	\$7,000 copayment /stay	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis. Prior authorization is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$40 copayment /visit	\$140 copayment /visit	120 visit limit - combination of network providers and out-of-network providers per person per plan year. Prior authorization is required for certain home health care services or there may be no coverage.
	Rehabilitation services	\$20 - \$75 copayment /visit	\$150 copayment /visit	30 visit limit for occupational therapy 30 visit limit for physical therapy 30 visit limit for speech therapy Maximums are a combination of network providers and out-of-network providers per person per plan year.
	Habilitation services	\$20 - \$75 copayment /visit	\$150 copayment /visit	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. These copayments may be updated on a regular basis. For mental health related therapies, see Section 5: Covered Health Services*
If you need help recovering or have other special health needs	Skilled nursing care	\$3,000 copayment /stay	\$6,000 copayment /stay	120 day limit per person per plan year. Prior authorization is required or there may be no coverage.
	Durable medical equipment (DME)	\$0 - \$1,000 copayment /equipment based on DME tier	\$20 - \$2,000 copayment /equipment based on DME tier	For DME tiers and limitations, visit www.choosebind.com/CCSD , (Active Access code: CCSD2021, COBRA Access code: CCSDcobra2021), the MyBind mobile app or www.MyBind.com website. Prior authorization is required for certain DME or there may be no coverage.
	Hospice services	Home: \$40 copayment /visit Inpatient: \$3,000 copayment /stay	Home: \$140 copayment /visit Inpatient: \$6,000 copayment /stay	Prior authorization is required for certain hospice services or there may be no coverage.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	One exam per person per plan year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your [plan](#) document for more information and a list of any other [excluded services](#).)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (25 visit limit per person per plan year)
- Chiropractic care (25 visit limit per person per plan year)
- Routine eye care (Adult) (limited to one exam per person per plan year.)
- Routine foot care (for certain conditions)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for the agency is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cms.gov/ccio. You may also contact Bind Help at 1-833-576-6494. 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: Bind Help at 1-833-576-6494.

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 1-576.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$0	■ Specialist copayment	\$15	■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$3,500	■ Hospital (facility) copayment	\$0	■ Hospital (facility) copayment	\$750
■ Other copayments	\$180	■ Other copayments	\$1,485	■ Other copayments	\$1,020
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost sharing		Cost sharing		Cost sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$3,680	Copayments	\$1,500	Copayments	\$1,800
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$3,700	The total Joe would pay is	\$1,500	The total Mia would pay is	\$1,800

Note: These numbers assume the patients have chosen [provider](#) at the minimum of the [copayment](#) range for all services with the exception of Peg's labor and delivery. Peg has chosen a [provider](#) at the maximum [copayment](#) range for her labor and delivery. For more information on the [network](#) and/or [copayments](#), please visit www.choosebind.com/CCSD, the MyBind mobile app, www.MyBind.com website, or call Bind Help at 1- 833-576-6494.

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