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.my.centivo.com or call 1-800-789-6445. 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 call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Providers: $350 Individual / $700 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Providers: $4,000 Individual / $8,000 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 https://my.centivo.com/ or call 1-800-789-6445 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 as this plan has no out-of-network coverage, except emergency services. 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 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
		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	$0 Copayment Deductible does not apply	Not Covered	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	$35 Copayment Deductible does not apply	Not Covered	
	Preventive care/screening/ immunization	$0 Copayment 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)	$0 Copayment Deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not Covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: **https://www.caremark.com** or call 1-888-698-0582.	Tier 1 - Generic drugs	**Retail:** $5 Copayment **Mail Order:** $10 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 90-day supply (mail order prescription). Maximum Copayment applies per prescription. Specialty drugs have 0% Coinsurance when utilizing PrudentRx. Deductible does not apply to prescription coverages.
	Tier 2 – Preferred brand drugs	**Retail:** 30% Coinsurance; $30 minimum Copayment; $60 maximum Copayment **Mail Order:** 30% Coinsurance; $60 minimum Copayment; $120 maximum Copayment	Not Covered	

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 at: **https://www.caremark.com** or call 1-888-698-0582.	Tier 3 – Non-preferred brand drugs	**Retail:** 60% Coinsurance; $60 minimum Copayment; $150 maximum Copayment **Mail Order:** 60% Coinsurance; $120 minimum Copayment; $300 maximum Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 90-day supply (mail order prescription). Maximum Copayment applies per prescription. Specialty drugs have 0% Coinsurance when utilizing PrudentRx. Deductible does not apply to prescription coverages.
	Tier 4 - Specialty drugs	30% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not Covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	10% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$200 Copayment Deductible does not apply	$200 Copayment Deductible does not apply	Copayment waived if admitted. All Emergency Services are considered in-network. Preauthorization is required for non-emergent Air Ambulance. Urgent care is same as in-network when outside of service area.
	Emergency medical transportation	$0 Copayment Deductible does not apply	$0 Copayment Deductible does not apply	
	Urgent care	$35 Copayment Deductible does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	10% Coinsurance	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	**Office Visit**: $0 Copayment **Partial Day Program:** $35 Copayment Deductible does not apply	Not Covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Inpatient services	10% Coinsurance	Not Covered	
If you are pregnant	Office visits	$35 Copayment Deductible does not apply	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain preauthorization for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in benefits being reduced.
	Childbirth/delivery professional services	10% Coinsurance	Not Covered	
	Childbirth/delivery facility services	10% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	Not Covered	Limited to 100 visits/year combined with Private Duty Nursing. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Rehabilitation services	$35 Copayment Deductible does not apply	Not Covered	Limited to 30 visits/year each. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$35 Copayment Deductible does not apply	Not Covered	
	Skilled nursing care	10% Coinsurance	Not Covered	Limited to 60 visits/year combined with Inpatient Medical Rehabilitation. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.

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)	
	Durable medical equipment	10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Hospice services	**Inpatient Facility:** 10% Coinsurance **Home:** $0 Copayment Deductible does not apply	Not Covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Coverage limited as required by PPACA.
	Children's glasses	Not Covered	Not Covered	Not a covered service under this plan.
	Children's dental check-up	Not Covered	Not Covered	Coverage is limited to an oral risk assessment each year as required by PPACA.

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
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care

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

- Acupuncture (Limited to 20 visits/year)
- Bariatric Surgery (provided by Lantern)
- Chiropractic Care (Limited to 20 visits/year)
- Hearing Aids (Limited to $3,000/year. Unlimited earmolds apply for children up to age 17)
- Infertility Treatment (provided by Progyny)
- Private Duty Nursing (Limited to 100 visits/year combined with Home Health Care)
- Weight Loss Programs (provided by Virta)

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 those agencies is: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or Affordable Care Act | U.S. Department of Labor (dol.gov) or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.CMS.gov. 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 on how 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 Centivo at 1-800-789-6445.You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or www.dol.gov/ebsa/healthreform.

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 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 1-800-789-6445.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-789-6445.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-789-6445.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-789-6445 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-789-6445.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-789-6445.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-789-6445.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-789-6445.

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** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$350
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,460**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$200
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$300
Copayments	$500
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.