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, https://my.centivo.com or call 1-800-582-5147. 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: $0/Individual or $0/Family, Out-of-Network Providers: $4,900/Individual or 9,800/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	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 Providers: $3,000/Individual or $6,000/Family, Out-of-Network Providers: $12,900/Individual or $25,800/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?	Copayments for certain services, 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 1-800-582-5147 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.
Do you need a referral to see a specialist?	Yes	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. Referrals are obtained by the primary care physician.

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	50% Coinsurance after deductible	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	$40 Copayment	50% Coinsurance after deductible	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive care/screening/ immunization	$0 Copayment	50% Coinsurance after deductible	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	50% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$150 Copayment	50% Coinsurance after deductible	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 www.medimpact.com or 1-844-587-7387	Tier 0 drugs	No charge	For retail, you pay the difference from the network cost. No mail order coverage provided.	Covers up to a 30-day supply (retail subscription); or 90-day supply (Preferred retail mail order).
	Tier 1 drugs	10% Coinsurance; Deductible does not apply	For retail, you pay the difference from the network cost. No mail order coverage provided.	For up to a 30-day supply, your payment will not be less than $10 or more than $30 per fill. For a 90-day supply, your payment will not be less than $25 or more than $75 per fill.
	Tier 2 drugs	20% Coinsurance; Deductible does not apply	For retail, you pay the difference from the network cost. No mail order coverage provided.	For up to a 30-day supply, your payment will not be less than $40 or more than $150 per fill. For a 90-day supply, your payment will not be less than $100 or more than $375 per fill.
	Tier 3 drugs	50% Coinsurance; Deductible does not apply	For retail, you pay the difference from the network cost. No mail order coverage provided.	For up to a 30-day supply, your payment will not be less than $70 or more than $300 per fill. For a 90-day supply, your payment will not be less than $175 or more than $750 per fill.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$700 Copayment	50% Coinsurance after deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	No Charge	50% Coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$250 Copayment	$250 Copayment	$250 penalty in addition to copayment for Non-emergent use of the Emergency Room Urgent care benefit same as in-network when outside of service area.
	Emergency medical transportation	$75 Copayment	$75 Copayment	
	Urgent care	$75 Copayment	50% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,100 Copayment	50% Coinsurance after deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	No Charge	50% Coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit** /$0 Copayment **All Other Outpatient:** $40 Copayment	50% Coinsurance after deductible	None
	Inpatient services	$1,100 Copayment	50% Coinsurance after deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If you are pregnant	Office visits	$40 Copayment	50% Coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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	No Charge	50% Coinsurance after deductible	
	Childbirth/delivery facility services	$1,100 Copayment	50% Coinsurance after deductible	
If you need help recovering or have	Home health care	$40 Copayment	50% Coinsurance after deductible	Limited to 120 days per plan year.

* For more information about limitations and exceptions, see the plan or policy document at https://my.centivo.com.

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)	
other special health needs	Rehabilitation services	$40 Copayment	50% Coinsurance after deductible	Includes physical therapy, speech therapy, and occupational therapy. Limited to 40 visits per plan year each.
	Habilitation services	$40 Copayment	50% Coinsurance after deductible	
	Skilled nursing care	$900 Copayment	50% Coinsurance after deductible	Limited to 120 days per plan year. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Durable medical equipment	$150 Copayment	50% Coinsurance after deductible	Preauthorization needed on DME over $1,500 or DME rentals more than $500/month. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	**Home:** $0 Copayment **Inpatient Facility:** $1,100 Copayment	50% Coinsurance after deductible	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.
- Private Duty Nursing
- Private Duty Nursing
- Routine eye care (Adult)
- Weight loss programs
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at https://my.centivo.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic Care (24 visits per plan year)	• Infertility Treatment	• Hearing Aids ($3,000 per ear per 36 months)

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 1-800-582-5147. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or 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 1 800-582-5147.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 800-582-5147.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1 800-582-5147.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 800-582-5147.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1 800-582-5147 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 800-582-5147.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1 800-582-5147.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1 800-582-5147.

*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)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$1,100
Other Rx coinsurance	20%

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	$1,100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,110**

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	$1,100
Other Rx coinsurance	20%

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	$80
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$780**

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	$1,100
Other Rx coinsurance	20%

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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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