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, www.mycentivo.com or call 1-855-221-2421. 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?	For In-Network: $0/Individual or $0/Family For Out-of-Network: $6,000/Individual or $12,000	For In-Network: See the Common Medical Event Chart Below for your costs for services this plan covers. For Out-of-Network: 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?	This plan has no deductible for In-Network services. Deductible applies on Out-of-Network services.	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?	For In-Network: $3,000/Individual or $6,000/Family For Out-of-Network: $25,000/Individual or $50,000/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.mycentivo.com or call 1-855-221-2421 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	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.

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 Provider		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the least)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copayment	50% coinsurance	None
	Specialist visit	$40 Copayment	50% coinsurance	None
	Preventive care/screening/ immunization	$0 Copayment	50% coinsurance	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)	$10 Copayment	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$200 Copayment	50% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Express Scripts	Generic drugs (Tier 1)	Retail: $7 Copayment Mail Order: $15 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 31–90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2) and Non-Preferred drugs (Tier 3)	**Retail:** 20% coinsurance with $40 minimum/$80 maximum **Mail Order:** 20% coinsurance with $80 minimum/$160 maximum	Not Covered	
	Specialty drugs	20% coinsurance with $40 minimum/$80 maximum	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copayment	50% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	$0 Copayment	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 Copayment	$200 Copayment	Preauthorization is required for non-emergent Air Ambulance. Urgent Care is same as in-network when outside of service area.
	Emergency medical transportation	Ground: $75 Copayment Air: $200 Copayment	Ground: $75 Copayment Air: $200 Copayment	
	Urgent care	$75 Copayment	50% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com.

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the least)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$800 Copayment	50% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	$0 Copayment	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Initial 6 Visits*:** $0 Copayment **Office Visit:** $40 Copayment **Partial Day Program:** $500 Copayment	50% coinsurance	*Initial 6 visits are provided through Springhealth. Preauthorization may be required.
	Inpatient services	$800 Copayment	50% coinsurance	Preauthorization may be required.
If you are pregnant	Office visits	$40 Copayment	50% coinsurance	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	$0 Copayment	50% coinsurance	
	Childbirth/delivery facility services	$800 Copayment	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 Copayment	50% coinsurance	Limited to 200 visits/calendar year.
	Rehabilitation services	$40 Copayment	50% coinsurance	Limited to 60 visits/calendar year combined with physical therapy, occupational therapy, speech therapy, and acupuncture.
	Habilitation services	$40 Copayment	50% coinsurance	
	Skilled nursing care	$800 Copayment	50% coinsurance	Limited to 120 days/calendar year. Preauthorization may be required.
	Durable medical equipment	$40 Copayment	50% coinsurance	Preauthorization may be required.
	Hospice services	$0 Copayment	50% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge of the contracted/permitted rate.		Coverage limited as required by PPACA.
	Children's glasses	Not Covered		Not a covered service under this plan.
	Children's dental check-up	No charge of the contracted/permitted rate.		Coverage is limited to an oral risk assessment each year as required by PPACA.

[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com.

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)
- Hearing Aids
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (Covered if prescribed for rehabilitation purposes. Combined with physical therapy, occupational therapy, & speech therapy for 60 visits/year)
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment (Only through Kindbody. Lifetime maximum of $20,000 applies)

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: Affordable Care Act | U.S. Department of Labor (dol.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 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: 1-855-221-2421 for ERISA: contact information for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll 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 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 1-855-221-2421.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-221-2421.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-221-2421.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-221-2421 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-221-2421.

[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-221-2421.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-221-2421.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-221-2421.

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

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[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com.

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	$800
Other coinsurance	N/A

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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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	$800
Prescription 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,110**

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	$800
Other coinsurance	N/A

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	$800
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.