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 1-800-981-8925. 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 $1,000/Individual or $2,000/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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For: In-Network: $4,000/Individual or $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 1-800-981-8925 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
		Network Provider (You will pay the least Referred by your PCP)	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	No Charge	Not Covered	Virtual visits and telephonic visits are the same as in-office visits. VPC (Virtual Primary Care) visits are No Charge.
	Specialist visit	$50 Copayment	Not Covered	Virtual visits and telephonic visits are the same as in-office visits. VPC (Virtual Primary Care) visits are No Charge.
	Preventive care/screening/ immunization	No Charge	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)	$20 Copayment	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$200 Copayment after Deductible	Not Covered	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **https://www.CerpassRx.com** or call **1-844-636-7506**.	Generic drugs	Retail: $10 Copayment per prescription; Mail Order: $20 Copayment per prescription	Not Covered	Deductible does not apply. Retail: Limited to a 30-day supply. An additional $10 Copayment applies when using Walgreens pharmacy. 90-day supply for maintenance drugs is available through mail order. If you or your provider choose a brand-name medication when a generic version is available, you will have to pay the brand cost sharing and the difference in cost when you fill this medication. Preauthorization from CerpassRx is required for all prescriptions over $1,000. Call 1-888-902-5533.
	Preferred brand drugs	Retail: $25 Copayment per prescription; Mail Order: $50 Copayment per prescription	Not Covered	
	Non-preferred brand drugs	Retail: $40 Copayment per prescription; Mail Order: $80 Copayment per prescription	Not Covered	
	Specialty drugs	20% Coinsurance up to a maximum of $125	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least Referred by your PCP)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copayment after Deductible	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge after Deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$500 Copayment	$500 Copayment	All Emergency Services are considered In Network. Copayment waived if admitted. Non-emergent use of the Emergency Room results in an additional $250 penalty. Urgent care is the same as in-network when outside of the service area.
	Emergency medical transportation	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
	Urgent care	$75 Copayment	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$900 Copayment after Deductible	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge after Deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office visits/Facility:** No Charge **Partial Day Program:** $50 Copayment	Not Covered	Preauthorization may be required.
	Inpatient services	$900 Copayment after Deductible	Not Covered	Preauthorization may be required.
If you are pregnant	Office visits	$50 Copayment	Not Covered	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 after Deductible	Not Covered	
	Childbirth/delivery facility services	$900 Copayment after Deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least Referred by your PCP)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$50 Copayment	Not Covered	90 visits per calendar year combined with Private Duty Nursing. Preauthorization may be required.
	Rehabilitation services	$50 Copayment	Not Covered	25 visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$50 Copayment	Not Covered	
	Skilled nursing care	**Facility:** $900 Copayment after Deductible **Physician:** No Charge after Deductible	Not Covered	90 days per calendar year combined with Inpatient Medical Rehabilitation. Preauthorization may be required.
	Durable medical equipment	$75 Copayment	Not Covered	Excludes vehicle and home modifications, exercise, and bathroom equipment. Preauthorization may be required.
	Hospice services	**Facility:** $900 Copayment after Deductible **Physician:** No Charge after Deductible	Not Covered	Preauthorization may be required.
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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Routine Eye Care
- Weight Loss Programs

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture (20 visits per calendar year)	• Chiropractic Care (30 visits per calendar year)	• Private Duty Nursing (90 visits per calendar year combined with Home Health Care)

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 1-800-981-8925.

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 1-800-981-8925.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-981-8925.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-981-8925.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-981-8925.

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	**$1,000**
Specialist copayment	**$50**
Hospital (facility) copayment	**$900**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,300**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) copayment	**$900**
Other coinsurance	**N/A**

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

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) copayment	**$900**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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