

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](http://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 <a href="#">deductible</a> ?	For: In- <a href="#">Network</a> \$1,000/Individual or \$2,000/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For: In- <a href="#">Network</a> : \$4,000/Individual or \$8,000/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://my.centivo.com">https://my.centivo.com</a> or call 1-800-981-8925 for a list of <a href="#">network providers</a>	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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.
	<u>Specialist</u> visit	\$50 <u>Copayment</u>	Not Covered	Virtual visits and telephonic visits are the same as in-office visits. VPC (Virtual Primary Care) visits are No Charge.
	<u>Preventive care/screening/</u> immunization	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 <u>Copayment</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$200 <u>Copayment</u> after <u>Deductible</u>	Not Covered	<u>Prauthorization</u> may be required.
If you need drugs to treat your illness or condition  More information about <a href="https://www.CerpassRx.com">https://www.CerpassRx.com</a> or call 1-844-636-7506.	Generic drugs	Retail: \$10 <u>Copayment</u> per prescription; Mail Order: \$20 <u>Copayment</u> per prescription	Not Covered	<u>Deductible</u> does not apply. Retail: Limited to a 30-day supply. An additional \$10 <u>Copayment</u> applies when using Walgreens pharmacy. 90-day supply for maintenance drugs is available through mail order. If you or your <u>provider</u> 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.
	Preferred brand drugs	Retail: \$25 <u>Copayment</u> per prescription; Mail Order: \$50 <u>Copayment</u> per prescription	Not Covered	<u>Prauthorization</u> from CerpassRx is required for all prescriptions over \$1,000. Call 1-888-902-5533.
	Non-preferred brand drugs	Retail: \$40 <u>Copayment</u> per prescription; Mail Order: \$80 <u>Copayment</u> per prescription	Not Covered	
	<u>Specialty drugs</u>	20% <u>Coinsurance</u> 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 <a href="#">Copayment</a> after <a href="#">Deductible</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	No Charge after <a href="#">Deductible</a>	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">Copayment</a>	\$500 <a href="#">Copayment</a>	All <a href="#">Emergency Services</a> are considered In Network. <a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a> after <a href="#">Deductible</a>	20% <a href="#">Coinsurance</a> after <a href="#">Deductible</a>	<a href="#">Non-emergent</a> use of the <a href="#">Emergency Room</a> results in an additional \$250 penalty.
	<a href="#">Urgent care</a>	\$75 <a href="#">Copayment</a>	Not Covered	<a href="#">Urgent care</a> is the same as in-network when outside of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$900 <a href="#">Copayment</a> after <a href="#">Deductible</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	No Charge after <a href="#">Deductible</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office visits/Facility:</b> No Charge <b>Partial Day Program:</b> \$50 <a href="#">Copayment</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
	Inpatient services	\$900 <a href="#">Copayment</a> after <a href="#">Deductible</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
If you are pregnant	Office visits	\$50 <a href="#">Copayment</a>	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain <a href="#">preauthorization</a> 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 <a href="#">Deductible</a>	Not Covered	
	Childbirth/delivery facility services	\$900 <a href="#">Copayment</a> after <a href="#">Deductible</a>	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	<u>Home health care</u>	\$50 <u>Copayment</u>	Not Covered	90 visits per calendar year combined with Private Duty Nursing. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	\$50 <u>Copayment</u>	Not Covered	25 visits per calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	<u>Habilitation services</u>	\$50 <u>Copayment</u>	Not Covered	
	<u>Skilled nursing care</u>	<b>Facility:</b> \$900 <u>Copayment</u> after <u>Deductible</u> <b>Physician:</b> No Charge after <u>Deductible</u>	Not Covered	90 days per calendar year combined with Inpatient Medical Rehabilitation. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	\$75 <u>Copayment</u>	Not Covered	Excludes vehicle and home modifications, exercise, and bathroom equipment. <u>Preauthorization</u> may be required.
	<u>Hospice services</u>	<b>Facility:</b> \$900 <u>Copayment</u> after <u>Deductible</u> <b>Physician:</b> No Charge after <u>Deductible</u>	Not Covered	<u>Preauthorization</u> 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 <u>plan</u> .
	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

## 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, kwijjigo holne' 1-800-981-8925.

***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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$900
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,300</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$900
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,100</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$900
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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