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 https://my.centivo.com or www.express-scripts.com or call Centivo at 1-866-661-1861 or Express Scripts at 1-800-987-5248. 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 Guided Care Providers:** $0/individual and $0/family **For Unguided Care Providers:** $3,000/individual and $6,000/family	**For Guided Care:** See the Common Medical Events chart below for your costs for services this plan covers. **For Unguided Care:** 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?	**For Guided Care:** Not applicable. This plan does not have a deductible. **For Unguided Care:** No.	**For Guided Care:** This plan does not have a deductible, but a copayment may apply. This plan covers certain preventive services without cost sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. **For Unguided Care:** You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**For Guided Care and Unguided Care:** No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For Guided Care Providers:** $3,500/individual and $7,000/family **For Unguided Care Providers:** $9,100/individual and $18,200/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, penalties for failure to obtain preauthorization, and health care or pharmacy services 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 1-866-661-1861 or www.express-scripts.com 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		Limitations, Exceptions, & Other Important Information
		Guided Care (You will pay the least)	Unguided Care (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	Deductible, then 50% coinsurance	Virtual visits and telephonic visits are the same copay as in-office visits.
	Specialist visit	$75 copayment/visit	Deductible, then 50% coinsurance	Virtual visits and telephonic visits are the same copay as in-office visits.
	Preventive care/screening/ immunization	No charge	Deductible, then 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Specialist:** $75 copayment/test **All Others:** $25 copayment/test	Deductible, then 50% coinsurance	Copayment does not apply when billed in conjunction with an office visit.
	Imaging (CT/PET scans, MRIs)	$300 copayment/test	Deductible, then 50% coinsurance	Preauthorization is 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.express-scripts.com	Generic drugs	**Retail:** 10% coinsurance; no deductible; $10 min copayment **Mail order:** 10% coinsurance; no deductible; $20 min and $200 max copayment	Out-of-network pharmacies are not covered	Out-of-network pharmacies are not covered. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Maintenance medications must be filled as 90 day supply through Express Scripts Mail Order or designated retail pharmacy. Certain preventive drugs (including contraceptives) – No charge
	Preferred brand drugs	**Retail:** 30% coinsurance; no deductible; $20 min copayment **Mail order:** 30% coinsurance; no deductible; $40 min and $200 max copayment	Out-of-network pharmacies are not covered	

* 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
		Guided Care (You will pay the least)	Unguided Care (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Non-preferred brand drugs	**Retail:** 50% coinsurance; no deductible; $40 min copayment **Mail order:** 50% coinsurance; no deductible; $80 min and $200 max copayment	Out-of-network pharmacies are not covered	When a member choose the brand name drug over the generic drug, the member will pay the applicable coinsurance and the cost difference between the brand and generic drugs. Preauthorization may be required for specific drugs. Specialty drugs must be filled through the Express Scripts mail order or designated specialty pharmacy.
	Specialty drugs	**Retail - Preferred:** 30% coinsurance; no deductible; $20 min copayment **Retail – Non-preferred:** 50% coinsurance; no deductible; $40 min copayment **Mail order - Preferred:** 30% coinsurance; no deductible; $40 min and $200 max copayment **Mail order – Non-preferred:** 50% coinsurance; no deductible; $80 min and $200 max copayment	Out-of-network pharmacies are not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copayment/visit	Deductible, then 50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	No charge	Deductible, then 50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Guided Care (You will pay the least)	Unguided Care (You will pay the most)	
If you need immediate medical attention	Emergency room care	$350 copayment/visit	$350 copayment/visit	Copayment waived if admitted. All Emergency Services are considered In Network. Air Ambulance must be medically necessary, and preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Emergency medical transportation	**Ground:** $250 copayment **Air:** $500 copayment	**Ground:** $250 copayment **Air:** $500 copayment	
	Urgent care	$100 copayment/visit	Deductible, then 50% coinsurance	In-service area applies to members using Unguided Care benefits with an In-Network Provider. Out of area applies to members who cannot access an In-Network Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	**Without surgical procedure:** $1,000 copayment **With surgical procedure:** $1,750 copayment	Deductible, then 50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	No charge	Deductible, then 50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit:** $25 copayment/visit **Partial Day Program & Substance Abuse Detox:** $500 copayment **All other outpatient services:** $75 copayment	Deductible, then 50% coinsurance	Preauthorization is required for Inpatient, Residential, and Partial Day Programs. If you don't get preauthorization, benefits may be reduced.
	Inpatient services	**Inpatient Hospital and Residential Treatment:** $1,000 copayment	Deductible, then 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Guided Care (You will pay the least)	Unguided Care (You will pay the most)	
If you are pregnant	Office visits	$25 copayment/visit	Deductible, then 50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment 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 a benefits being reduced.
	Childbirth/delivery professional services	No charge	Deductible, then 50% coinsurance	
	Childbirth/delivery facility services	**Vaginal delivery:** $1,000 copayment **Cesarean delivery:** $1,750 copayment	Deductible, then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$75 copayment/visit	Deductible, then 50% coinsurance	Limited to 120 visits per calendar year and is combined with Private Duty Nursing in home setting. Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Rehabilitation services	$75 copayment/visit	Deductible, then 50% coinsurance	Occupational Therapy and Physical Therapy are limited to 60 visits combined, per calendar year. Preauthorization is required after 40 visits. If you don't get preauthorization, benefits may be reduced. Respiratory/Pulmonary Therapy is limited to 20 visits per calendar year. Cardiac Therapy is limited to 36 visits per calendar year.
	Habilitation services	$75 copayment/visit	Deductible, then 50% coinsurance	
	Skilled nursing care	$1,000 copayment	Deductible, then 50% coinsurance	Limited to 60 days per episode, per calendar year combined with Inpatient Medical Rehabilitation. Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Durable medical equipment	$100 copayment	Deductible, then 50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	Deductible, then 50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Guided Care (You will pay the least)	Unguided Care (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage is limited as required under PPACA.
	Children's glasses	Not covered	Not covered	Children's glasses are 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric Surgery (limitations apply)
- Chiropractic Care (limitations apply)
- Hearing Aids (limitations apply)
- Infertility Treatment (limitations apply)
- Private Duty Nursing (limitations apply)

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 1-866-661-1861 or Express Scripts at 1-800-996-6734 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 the 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 1-866-661-1861.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-661-1861.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-661-1861.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-661-1861.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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**
- **Prenatal care office visit copayment** **$25**
- **Hospital (facility) copayment*** **$1,000**
- **Other coinsurance** **N/A**

This EXAMPLE event includes services like:
Prenatal care office visits
Vaginal Childbirth/Delivery Professional Services
Vaginal 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	$1,410
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,410**

***The above example is for a vaginal delivery and shows applicable cost-sharing.**

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** **$75**
- **Hospital (facility) copayment** **$1,000**
- **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	$350
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,550**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$75**
- **Hospital (facility) copayment** **$1,000**
- **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	$0
Copayments	$1,510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,510**

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

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