



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 www.my.centivo.com or call 1-888-391-7788. 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 ?	\$500 Individual / \$1,000 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. There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,500 Individual / \$5,000 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 ?	Not Applicable. You may call 1-888-391-7788 or visit www.my.centivo.com for more information.	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without referral .



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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copayment (Deductible does not apply)	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	\$40 Copayment (Deductible does not apply)	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive care/screening/immunization	\$0 Copayment (Deductible does not apply)	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)	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://liviniti.com/ or call 1-800-710-9341.	Tier 1 - Generic drugs	Retail: \$10 Copayment Mail Order: \$20 Copayment	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Deductible does not apply for prescription drug coverage .
	Tier 2 - Preferred brand drugs	Retail: \$35 Copayment Mail Order: \$70 Copayment	
	Tier 3 - Non-preferred brand drugs	Retail: \$60 Copayment Mail Order: \$120 Copayment	
	Tier 4 - Specialty drugs	Retail Only: \$175 Copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Preauthorization may be required.
	Physician/surgeon fees	30% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	\$250 Copayment (Deductible does not apply)	Copayment waived if admitted.
	Emergency medical transportation	30% Coinsurance	All Emergency Services are considered in-network.
	Urgent care	\$40 Copayment (Deductible does not apply)	Preauthorization is required for non-emergent Air Ambulance.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	30% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 Copayment (Deductible does not apply) Partial Day Program: 30% Coinsurance	Preauthorization may be required.
	Inpatient services	30% Coinsurance	
If you are pregnant	Office visits	\$40 Copayment (Deductible does not apply)	Cost sharing does not apply to certain preventive services . Depending on the type of services, copayment , coinsurance , and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Please obtain preauthorization for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery.
	Childbirth/delivery professional services	30% Coinsurance	
	Childbirth/delivery facility services	30% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Limited to 90 visits/year combined with Private Duty Nursing. Preauthorization may be required.
	Rehabilitation services	\$40 Copayment (Deductible does not apply)	Occupational Therapy and Speech Therapy for those under age 19 have unlimited visits if medically necessary. Otherwise, visits are limited to 25 visits/year each which includes Physical Therapy, Speech Therapy, and Occupational Therapy.
	Habilitation services	\$40 Copayment (Deductible does not apply)	
	Skilled nursing care	30% Coinsurance	Limited to 90 visits/year combined with Inpatient Medical Rehabilitation. Preauthorization may be required.
	Durable medical equipment	30% Coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required.
	Hospice services	30% Coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Coverage limited as required by PPACA.
	Children's glasses	Not Covered	Not a covered service under this plan .
	Children's dental check-up	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)	- Infertility Treatment - 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.)		
- Acupuncture (Limited to 20 visits/year) - Chiropractic Care (Limited to 30 visits/year)	Hearing Aids (Unlimited dollar amount for ages 21 and under and limited to \$2,500/year for ages 22 and over. Covered every 36 months regardless of age.)	Private Duty Nursing (Limited to 90 visits/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 1-888-391-7788. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or [www.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 1-888-391-7788.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-391-7788.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-391-7788.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-888-391-7788 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-391-7788.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-391-7788.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-391-7788.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-391-7788.

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	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,500

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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