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 call 1-833-666-1302 or contact your Human Resources Department. 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 network providers: $0/individual and $0/family	See the Common Medical Events Chart below for your costs for services this plan covers.
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 does not have a deductible, but a copayment or coinsurance 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/.
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 network providers: $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, services not deemed medically necessary, 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 1-833-666-1302 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
		Network Provider (You will pay the least)	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 copay as in-office visits.
	Specialist visit	$40 copayment/visit	Not covered	Virtual visits and telephonic visits are the same copay as in-office visits.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copayment/test	Not covered	Preauthorization is required for PET scans. If you don't get preauthorization, benefits may be reduced by $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-844-635-3401	**Generic drugs (Tier 1)**	**Retail:** No charge **Mail Order/CVS Pharmacy:** No charge	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order/CVS Pharmacy prescription). Mandatory 90 day supply for maintenance medications through mail or CVS pharmacy. Up to three fills at retail allowed for maintenance medications. CVS Caremark is the pharmacy for specialty medications. $0 copay for applicable specialty medications for members enrolled in PrudentRx Copay Program. Some medications such as self-injectables are not covered in the medical plan. Contact plan for details.
	Preferred brand drugs (Tier 2)	**Retail:** $25 copayment **Mail Order/CVS Pharmacy:** $50 copayment	Not covered	
	Non-preferred brand drugs (Tier 3)	**Retail:** $150 copayment **Mail Order/CVS Pharmacy:** $300 copayment	Not covered	
	Specialty drugs	30% coinsurance	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
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copayment/visit	Not covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced by $500.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copayment/visit	$250 copayment/visit	Copayment waived if admitted. All Emergency Services are considered In Network. Non-Emergency use of the Emergency Room is not covered.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$100 copayment/visit	$100 copayment/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment	Not covered	Preauthorization is required. If you don't get preauthorization, benefits may be reduced by $500.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office:** No charge **Partial Day Program:** $300 copayment	Not covered	Preauthorization is required for Inpatient, Residential, and Partial Day Programs. If you don't get preauthorization, benefits may be reduced by $500.
	Inpatient services	$500 copayment	Not covered	
If you are pregnant	Office visits	$40 copayment/visit	Not covered	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 or 96 hours for cesarean delivery may result in a $500 penalty.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copayment	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$40 copayment/visit	Not covered	Limited to 40 visits per calendar year. Preauthorization is required. If you don't get preauthorization, benefits may be reduced by $500.
	Rehabilitation services	$40 copayment/visit	Not covered	Occupational Therapy, Physical Therapy, and Speech Therapy, are subject to 30 combined visits per Calendar Year.
	Habilitation services	$40 copayment/visit	Not covered	
	Skilled nursing care	$500 copayment	Not covered	Limited to 120 days per episode, with a 90 day renewal, per calendar year. Preauthorization is required. If you don't get preauthorization, benefits may be reduced by $500.
	Durable medical equipment	No charge	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	**Inpatient:** $500 copayment **Outpatient:** $300 copayment	Not covered	Preauthorization is required. If you don't get preauthorization, benefits may be reduced by $500.
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.)

- 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.)

- Acupuncture (limitations apply)
- Bariatric Surgery
- Chiropractic Care (limited to 30 visits/calendar year)
- Hearing Aids
- Infertility Treatment (limitations apply)
- Private Duty Nursing

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

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 1-833-666-1302. 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 1-833-666-1302.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-666-1302.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-666-1302.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-666-1302.

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

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**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$500**
- **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	**$12,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$700**

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** **$500**
- **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	**$4,700**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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** **$500**
- **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	**$2,100**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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