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 1-877-228-4298. 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?	**Coordinated and Uncoordinated Care:** $0 Individual / $0 Family	See the Common Medical Event Chart Below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible, but a copayment or coinsurance may apply.
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?	**Coordinated and Uncoordinated Care:** $4,000 Individual / $12,000 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 my.centivo.com or call 1-877-228-4298 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 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
		Coordinated Care (You will pay the least)	Uncoordinated 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	$0/$25 Copayment	$25 Copayment	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	$0 Copayment	$40 Copayment	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive care/screening/ immunization	$0 Copayment	$0 Copayment	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)	$0 Copayment	**Office**: $0 Copayment **Outpatient hospital:** $55 Copayment then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	**Office:** $0 Copayment **Outpatient Hospital:** $275 Copayment then 20% coinsurance	**Office:** $0 Copayment **Outpatient Hospital:** $275 Copayment then 20% coinsurance	Preauthorization may be 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 **https://vytlone.com/** or call VytlOne 1-800-687-0707.	Tier 1 - Generic drugs	**30-Day Retail Supply at *Wal-Mart/Moore's Pharmacy:*** $0 Copayment ***All other Network Pharmacies*:** $10 Copayment **90-Day Supply at Walmart or Mail order:** $0 Copayment	**30-Day Retail Supply at *Wal-Mart/Moore's Pharmacy:*** $0 Copayment ***All other Network Pharmacies*:** $10 Copayment **90-Day Supply at Walmart or Mail order:** $0 Copayment	Covers up to a 30-day supply (retail subscription); 31–90-day supply (mail order prescription).
	Tier 2 - Preferred brand drugs	**30-Day Supply at Retail:** The greater of $35 or 50% (up to a maximum of $100 per Rx) **Up to 90-Day Supply at Walmart or Mail order:** The greater of $70 or 50% (up to a maximum of $200 per Rx)	**30-Day Supply at Retail:** The greater of $35 or 50% (up to a maximum of $100 per Rx) **Up to 90-Day Supply at Walmart or Mail order:** The greater of $70 or 50% (up to a maximum of $200 per Rx)	
	Tier 3 - Non-preferred brand drugs	**30-Day Retail Supply:** The greater of $35 or 50% (up to a maximum of $100 per Rx) **Up to 90-Day supply at Walmart or Mail order:** The greater of $70 or 50% (up to a max of $200 per Rx)	**30-Day Retail Supply:** The greater of $35 or 50% (up to a maximum of $100 per Rx) **Up to 90-Day supply at Walmart or Mail order:** The greater of $70 or 50% (up to a max of $200 per Rx)	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Coordinated Care (You will pay the least)	Uncoordinated Care (You will pay the most)	
	Tier 4 - Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 Copayment	$330 Copayment then 20% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment	$110 Copayment	None
If you need immediate medical attention	Emergency room care	**Emergency:** $300 Copayment **Non-Emergency:** $500 Copayment	**Emergency:** $300 Copayment **Non-Emergency:** $500 Copayment	Emergency room care copayment waived if admitted. All Emergency Services are considered in-network. Free-standing emergency room facilities are not covered.
	Emergency medical transportation	$300 Copayment	$300 Copayment	
	Urgent care	$40 Copayment	$40 Copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 Copayment	$550 Copayment then 20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment	$110 Copayment	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 Copayment	**Office:** $40 Copayment **Partial Day Program:** $550 Copayment then 20% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Inpatient services	$0 Copayment	$550 Copayment then 20% coinsurance	
If you are pregnant	Office visits	$0 Copayment	$0 Copayment	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). 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	$0 Copayment	$330 Copayment	
	Childbirth/delivery facility services	$0 Copayment	$275 Copayment	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Coordinated Care (You will pay the least)	Uncoordinated Care (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$0 Copayment	$55 Copayment	60 visits/year.
	Rehabilitation services	$0 Copayment	$40 Copayment	Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$0 Copayment	$40 Copayment	
	Skilled nursing care	$0 Copayment	$550 Copayment then 20% coinsurance	60 days/year. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Durable medical equipment	$165 Copayment	$165 Copayment	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Hospice services	$0 Copayment	**Outpatient:** $55 Copayment/day **Inpatient:** $550 Copayment/occurrence **Bereavement:** $55 Copayment/visit	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced. **Bereavement** is limited to 6 visits per family.
If your child needs dental or eye care	Children's eye exam	$0 Copayment	$0 Copayment	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	$0 Copayment	$0 Copayment	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)
- Hearing aids
- 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.)

- Bariatric surgery
- Chiropractic care (20 visit limit at $0 Copayment, then $40 Copayment)
- Private duty nursing (Inpatient only – $550 Copayment /Inpatient)

* 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 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: for Plan: Centivo at 1-877-228-4298. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-877-228-4298
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-228-4298
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-228-4298
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-228-4298 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-228-4298
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-228-4298
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-228-4298
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-228-4298

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 coordinated pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment** (Primary Care) **$25**

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
(coordinated emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment** (Emergency Care) **$300**

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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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