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 1-833-452-2888. 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?	Network Providers: $0 Out-of-Network Providers: $3,250 Individual / $6,500 Individual plus spouse or child(ren) / $9,750 Family	Generally, you must pay all the costs from the providers up to the deductible before this plan begins paying. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Providers: $3,900 Individual* / $7,800 Individual plus spouse or child(ren) / $11,700 Family Out-of-Network Providers: Unlimited	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. *$3,900 is maximum that any one person will satisfy towards the annual family out-of-pocket.
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 1-833-452-2888 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. Referrals are obtained from your primary care physician.

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	$0 Copayment	40% Coinsurance after Deductible	Virtual visits and telephonic visits are the same as in-office visits. Virtual visits with a Mutual Health Center provider are free.
	Specialist visit	$50 Copayment	40% Coinsurance after Deductible	Virtual visits and telephonic visits are the same as in-office visits. Virtual visits with a Mutual Health Center provider are free.
	Preventive care/screening/ immunization	$0 Copayment	40% Coinsurance 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)	**PCP Office:** $0 Copayment **Specialist Office/Facility:** $50 Copayment	40% Coinsurance after Deductible	None
	Imaging (CT/PET scans, MRIs)	$150 Copayment	40% Coinsurance after Deductible	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://www.rightwayhealthcare.com/** or call 1-833-502-7079.	Generic drugs (Tier 1)	Retail: $10 Copayment Mail: $25 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 31–90-day supply (mail order prescription). Not all prescription drugs are covered under the plan. To determine if a specific drug is covered, log into your account at www.rightwayhealthcare.com. For specialty drugs covered under the Rightway Copay Assistance Program (CAP), members will pay the copayment associated with the manufacturer's assistance program.
	Preferred drugs (Tier 2)	Retail: $30 Copayment Mail: $75 Copayment	Not Covered	
	Non-Preferred drugs (Tier 3)	Retail: $50 Copayment Mail: $125 Copayment	Not Covered	
	Specialty drugs (Tier 4)	$100 Copayment	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)	$500 Copayment	40% Coinsurance after Deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$250 Copayment	40% Coinsurance after Deductible	None
If you need immediate medical attention	Emergency room care	$500 Copayment	$500 Copayment Deductible does not apply	Copayment waived if admitted. If admitted, notification to the plan must be made within 48 hours. Preauthorization is required for non-emergent Air Ambulance.
	Emergency medical transportation	$150 Copayment	$150 Copayment Deductible does not apply	
	Urgent care	$75 Copayment	40% Coinsurance after Deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 Copayment	40% Coinsurance after Deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	**Surgeon:** $500 Copayment **All Others:** $0 Copayment	40% Coinsurance after Deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Partial Day Program** $750 Copayment **Outpatient Detox:** $500 Copayment **All Others:** $25 Copayment	40% Coinsurance after Deductible	All Mutual Health Center office visits are FREE. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced. Detox is covered when part of substance abuse treatment program only.
	Inpatient services	$750 Copayment	40% Coinsurance after Deductible	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If you are pregnant	Office visits	$0 Copayment	40% Coinsurance after Deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$500 Copayment	40% Coinsurance after Deductible	

* 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)	
	Childbirth/delivery facility services	$750 Copayment	40% Coinsurance after Deductible	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.
If you need help recovering or have other special health needs	Home health care	$50 Copayment	40% Coinsurance after Deductible	100 visits/year. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Rehabilitation services	$50 Copayment	40% Coinsurance after Deductible	All Mutual Health Center physical therapy visits are FREE. 60 combined visits/year. Includes physical therapy, speech therapy, respiratory therapy, aquatic therapy, and occupational therapy.
	Habilitation services	$50 Copayment	40% Coinsurance after Deductible	
	Skilled nursing care	$750 Copayment	40% Coinsurance after Deductible	120 visits/year combined with Inpatient Medical Rehabilitation. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Durable medical equipment	**Up to $1,000 purchase price:** $0 Copayment **$1,001-$3,000 purchase price:** $200 Copayment **Above $3,000 purchase price:** $400 Copayment	40% Coinsurance after Deductible	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	40% Coinsurance after Deductible	Bereavement Counseling is limited to 6 visits per participant per Calendar Year. Facility fee will apply if serviced within inpatient facility.

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 your child needs dental or eye care	Children's eye exam	$0 Copayment	40% Coinsurance after Deductible	Routine eye exam covered 1 visit/year up to age 21. Eye refractions are only covered if related to a covered medical condition.
	Children's glasses	Not Covered	Not Covered	Not a covered service under this plan.
	Children's dental check-up	*Based on place of service*	*Based on place of service*	Coverage only applies to children under age 5 or services determined to be medically necessary for individuals who are severely disabled or for individuals with serious medical conditions. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.

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**
- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (Adult)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing**
- **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.)

- **Chiropractic Care** (Limited to 24 visits/year)
- **Infertility treatment** (In-network through Kindbody)
- **Hearing Aids** ($5,000 lifetime maximum)

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 1-833-452-2888. 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 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 1-833-452-2888.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-452-2888.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-452-2888.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-452-2888 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-452-2888.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-452-2888.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-452-2888.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-452-2888.

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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$750
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	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,920**

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	$50
Hospital (facility) copayment	$750
Other coinsurance	0%

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$750
Other coinsurance	0%

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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