



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 1-855-521-8155 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](http://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 <a href="#">deductible</a> ?	For <a href="#">network providers</a> : \$0/individual and \$0/family	See, the Common Medical Events Chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> does not have a <a href="#">deductible</a> , but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> : \$2,500 individual / \$5,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, services not deemed <a href="#">medically necessary</a> , penalties for failure to obtain <a href="#">preauthorization</a> , and health care or pharmacy services this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://my.centivo.com/">https://my.centivo.com</a> or call 1-855-521-8155 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> 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.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit	Not covered	Virtual visits and telephonic visits are the same copay as in-office visits.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copayment</a> /test	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	Retail: 50% <a href="#">Coinsurance</a>	Not covered	Retail \$8 max for 30 day, mail order \$24 max for 90 day generic drugs. <a href="#">Provider</a> means pharmacy for the purposes of this section. See the website listed for information on drugs covered by your <a href="#">plan</a> . Not all drugs are covered.
	Brand drugs (Tier 2)	Retail: 50% <a href="#">Coinsurance</a>	Not covered	If no generic available: Retail \$100 max for 30 day, mail order \$300 max for 90 day single source brand name drugs.  If a generic is available: Generic copay of \$10 for 30 day at retail and generic copay of \$30 for 90 day at mail plus cost difference between brand and generic for multi-source brand name drugs.

\* 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)	
	<a href="#">Specialty drugs</a> (Tier 3)	\$0 after deductible if drug is on PrudentRx drug list and member is enrolled in the PrudentRx program (30% coinsurance before deductible). 30% coinsurance if not on PrudentRx drug list and not enrolled in the PrudentRx program.	Retail: Not covered	\$0 max copay for PrudentRx eligible drugs. PrudentRx is a specialty drug copay coupon program that applies to all Crewmembers and dependents in this plan. Most specialty drugs are covered under this program. Fertility medications are not included in the PrudentRx program.  For Non-PrudentRx drugs / enrollees: Retail \$200 max for 30 day. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by CVS Caremark.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$500 <a href="#">copayment</a> /visit	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copayment</a> /visit		Emergency Room <a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$200 <a href="#">copayment</a>		
	<a href="#">Urgent care</a>	\$100 <a href="#">copayment</a> /visit		All <a href="#">Emergency Services</a> are considered In Network.  Air Ambulance must be <a href="#">medically necessary</a> , and <a href="#">preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Without surgical procedure: \$100 <a href="#">copayment</a> With surgical procedure: \$700 <a href="#">copayment</a>	Not covered	Inpatient Medical Rehabilitation is limited to 120 days per calendar year and is combined with Skilled Nursing Facility. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	Physician/surgeon fees	No charge	Not covered	None

\* 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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">copayment</a> /visit	Not covered	<a href="#">Preauthorization</a> is required for Inpatient, Residential, and Partial Day Programs. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	Inpatient services	Inpatient Hospital and Residential Treatment: \$100 <a href="#">copayment</a> Partial Day Program: \$500 <a href="#">copayment</a>	Not covered	
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain <a href="#">preauthorization</a> 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	No charge	Not covered	
	Childbirth/delivery facility services	\$700 <a href="#">copayment</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <a href="#">copayment</a> /visit	Not covered	Limited to 40 visits per calendar year and is combined with Private Duty Nursing in home setting.  <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copayment</a> /visit	Not covered	Limited to 75 visits per calendar year and is combined Occupational Therapy, ABA Therapy, Physical Therapy, and Speech Therapy. <a href="#">Preauthorization</a> is required after 40 visits. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copayment</a> /visit	Not covered	
	<a href="#">Skilled nursing care</a>	\$100 <a href="#">copayment</a>	Not covered	Limited to 120 days per calendar year and is combined with Inpatient Medical Rehabilitation. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.

\* 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)	
	<a href="#">Durable medical equipment</a>	\$100 <a href="#">copayment</a>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> is required for items over \$1,000, purchase or accumulated rental. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits may be reduced.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Out of network not covered.
	Children's glasses	Not covered	Not covered	Children's glasses are not a covered service under this <a href="#">plan</a> .
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture (20 visit limit per plan year combined with Non Ash benefit)</li> <li>• Hearing Aids (only bone anchored &amp; middle ear implants)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery (Must be 18 years of age or older)</li> <li>• Chiropractic Care (20 visit max per plan year)</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment (\$25000 Max per lifetime Combined all Infertility / Fertility benefits)</li> <li>• Private Duty Nursing (40 visit max per plan year combine with Home Health)</li> </ul>

**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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://my.centivo.com>.

**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 1-855-521-8155. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or [dol.gov/ebsa/healthreform](https://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](#).

*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
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$700
- Other [coinsurance](#) 50% Rx

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1000
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,070</b>

### 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](#) \$700
- Other [coinsurance](#) 50% Rx

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### 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](#) \$700
- Other [coinsurance](#) 50% Rx

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855)-521-8155.

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855)-521-8155. ይደውሉ።

. (855)-521-8155 Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855)-521-8155.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855)-521-8155:

**Bassa (Básóó Wùdù):** M̄ dyi dyi-diè-dè b̄é b̄édé b̄á céè-dè n̄ià ke dyí ní, ɔ m̄ò n̄i dyí-b̄èd̄èin-dè b̄é m̄ ké gbo-kpá-kpá kè b̄ǐ kp̄ǒ dé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuḍu-zìin-nyò d̄ò gbo wùdù ke, d̄á (855)-521-8155.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855)-521-8155 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855)-521-8155 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855)-521-8155。

**Dinka (Dinka):** Na n̄ɔŋ thiëc n̄e ke de yā thorē, ke yin n̄ɔŋ loŋ b̄é yi kuony ku w̄er alēu b̄é ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāāuē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin c̄ol (855)-521-8155.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855)-521-8155.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855)-521-8155 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855)-521-8155.



## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855)-521-8155.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855)-521-8155.

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ເພື່ອໄວ້ລິມັດກັບວ່າມແປພາສາ, ໃຫ້ໂທຫາ (855)-521-8155.

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