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 1-833-433-1410 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?	In-Network Providers: $0 Individual / $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?	Not Applicable	This plan does not have a deductible, but a copayment or coinsurance may apply.
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?	In-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, 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 1-833-433-1410 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 as this plan has no out-of-network coverage, except emergency services. 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 by the 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	Not covered	Virtual visits and telephonic visits are covered the same as in-office visits. Includes internal medicine, pediatrics, general/family practice and geriatric care.
	Specialist visit	$25 Copayment	Not covered	Virtual visits and telephonic visits are covered the same as in-office visits.
	Preventive care/screening/ immunization	$0 Copayment	Not covered	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. The first mammogram, sonogram, and colonoscopy received in the calendar year is covered regardless of age or diagnosis.
If you have a test	Diagnostic test (x-ray, blood work)	**PCP & Outpatient Labs:** $0 Copayment **Specialist & Outpatient X-ray:** $25 Copayment	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 Copayment (per test)	Not covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced. Includes MRI, MRA, CAT Scan, PET Scan, etc. at an outpatient facility or office visit.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at joinrightway.com/rx or call 1-833-502-8990	Tier 1 - Generic drugs	**Retail:** $10 Copayment **Mail Order:** $25 Copayment	Not covered	Covers up to a 30-day supply (retail subscription); 31–90-day supply (retail or mail order prescription). After the third refill of a maintenance medication, you will be required to fill your prescription as a 90-day supply through either a retail pharmacy or mail-order pharmacy. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Tier 2 – Preferred brand drugs	**Retail:** $30 Copayment **Mail Order:** $75 Copayment	Not covered	
	Tier 3 – Non-preferred brand drugs	**Retail:** $50 Copayment **Mail Order:** $125 Copayment	Not covered	
	Tier 4 - Specialty drugs	**Retail (30 day):** **Generic:** $20 Copayment **Preferred:** $87.50 Copayment **Non-Preferred:** $150 Copayment **Mail Order (90 day):** **Generic:** $60 Copayment **Preferred:** $262.50 Copayment **Non-Preferred:** $450 Copayment	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment	Not covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment	Not covered	None
If you need immediate medical attention	Emergency room care	$250 Copayment	$250 Copayment	Copayment waived if admitted. If admitted, notification to the plan must be made within 48 hours. All Emergency Services are considered In Network. Air Ambulance must be medically necessary, and preauthorization is required for facility to facility transport.
	Emergency medical transportation	$0 Copayment	$0 Copayment	
	Urgent care	**Free Standing Facility:** $50 Copayment **Virtual Visit:** $0 Copayment	**Free Standing Facility:** $50 Copayment **Virtual Visit:** $0 Copayment	

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 a hospital stay	Facility fee (e.g., hospital room)	$250 Copayment per day, up to $750 maximum	Not covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Physician/surgeon fees	$0 Copayment	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Office visits for individual therapy	$0 Copayment	Not covered	Preauthorization is required for Inpatient, Residential, and Partial Day Programs. No Copayment applies for professional fees in conjunction with an inpatient or outpatient program stay.
	Outpatient services	$0 Copayment	Not covered	
	Inpatient services	$250 Copayment per day, up to $750 maximum	Not covered	
If you are pregnant	Office visits (OB-GYN)	**Routine Prenatal Visits:** $0 Copayment **Specialist Visits:** $25 Copayment	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). Preauthorization for childbirth is only required if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery.
	Childbirth/delivery professional services	$0 Copayment	Not covered	
	Childbirth/delivery facility services	$250 Copayment per day, up to $750 maximum	Not covered	
If you need help recovering or have other special health needs	Home health care	$25 copayment	Not covered	Limited to 90 visits per calendar year. Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
	Rehabilitation services	$25 copayment	Not covered	No limit applies to physical therapy, speech therapy, occupational therapy, and pulmonary/respiratory therapy.
	Habilitation services	$25 copayment	Not covered	
	Skilled nursing care	$250 copayment per day, up to $750 maximum	Not covered	Limited to 90 days per calendar year. Preauthorization may be required to validate continued medical necessity. If you don't get

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)	
				preauthorization, benefits may be reduced.
	Durable medical equipment	$40 Copayment	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	**Home/Outpatient:** $0 Copayment **Inpatient:** $250 Copayment per day, up to $750 maximum	Not covered	Preauthorization may be required. If you don't get preauthorization, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	No charge of the contracted/permitted rate.	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	No charge of the contracted/permitted rate.	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.
- Private Duty Nursing
- 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 (20 visits per calendar year)
- Bariatric Surgery
- Chiropractic Care (20 visits per calendar year)
- Hearing Aids (limit $3,000 maximum per ear every 3 years, including repair/ replacement
- Infertility Treatment (Lifetime max $25,000)
- Routine eye care (Adult Limited to one exam per calendar year)

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 1-833-433-1410. 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 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 1-833-433-1410.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-433-1410.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-433-1410.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-433-1410 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-433-1410.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-433-1410.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-433-1410.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-433-1410.

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** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$250/day**
- **Other copayment** **$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	$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** **$25**
- **Hospital (facility) copayment** **$250/day**
- **Other copayment** **$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** **$25**
- **Hospital (facility) copayment** **$250/day**
- **Other copayment** **$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	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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