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, www.mycentivo.com or call 1-855-950-6295. 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?	$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?	$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, 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 www.mycentivo.com or call 1-855-950-6295 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	Network Provider You will pay the least	Out of Network Provider You will pay the most	Limitations, Exceptions, & Other Important Information
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 as in-office visits. Walmart Health Virtual Care (WHVC) is also available for no charge: https://walmarthealthvirtualcare.com
	Specialist visit	$50 Copayment	Not Covered	Virtual visits and telephonic visits are the same as in-office visits. Walmart Health Virtual Care (WHVC) is also available for no charge: https://walmarthealthvirtualcare.com
	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 you need 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)	**Office:** $50 Copayment **Outpatient:** $100 Copayment	Not Covered	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optum.com	Tier 1 drugs	Retail: $10 Copayment Mail Order: $25 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription); 31–90-day supply (mail order prescription).
	Tier 2 drugs	Retail: $30 Copayment Mail Order: $75 Copayment	Not Covered	
	Tier 3 drugs	Retail: $60 Copayment Mail Order: $150 Copayment	Not Covered	
	Specialty drugs	Tier 1: $10 Copayment Tier 2: $30 Copayment Tier 3: $60 Copayment	Not Covered	Covers up to a 30-day supply (retail subscription).

[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com

Common Medical Event	Services You May Need	Network Provider You will pay the least	Out of Network Provider You will pay the most	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Ambulatory:** No Charge **All Others:** $400 Copayment	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 Copayment	$250 Copayment	Non-emergent use of the Emergency Room is not covered. Urgent Care will apply the in-network benefit when you are outside of the service area.
	Emergency medical transportation	$250 Copayment	$250 Copayment	
	Urgent care	$75 Copayment	$150 Copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	$800 Copayment	Not covered	Preauthorization may be required.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Partial Day Program/Detox:** $400 Copayment **All others:** No Charge	Not Covered	Preauthorization may be required.
	Inpatient services	**Facility:** $800 Copayment **Physician:** No Charge	Not covered	
If you are pregnant	Office visits	No Charge	Not Covered	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). 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	No Charge	Not Covered	
	Childbirth/delivery facility services	$800 Copayment	Not Covered	

[* For more information about limitations and exceptions, see the plan or policy document at www.mycentivo.com

Common Medical Event	Services You May Need	Network Provider You will pay the least	Out of Network Provider You will pay the most	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	$50 Copayment	Not Covered	120 visits/year combined with Private Duty Nursing.
	Rehabilitation services	$50 Copayment	Not Covered	60 visits/year combined with Occupational Therapy, Physical Therapy, and Speech Therapy for rehabilitation services.
	Habilitation services	$50 Copayment	Not Covered	
	Skilled nursing care	$800 Copayment	Not Covered	60 days/year. Preauthorization may be required.
	Durable medical equipment	$100 Copayment	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$50 Copayment	Not Covered	Limited to 1 exam every 24 months.
	Children's glasses	Not Covered	Not Covered	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.)

- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (Adult)**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **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** (if prescribed for anesthesia purposes)
- **Chiropractic care** (25 visits/year)
- **Hearing aids** ($400 maximum/year)
- **Private-duty nursing** (120 visits combined with Home Health Care/year)
- **Routine eye care** (Adults & Children – Limited to 1 exam every 24 months)

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: Affordable Care Act | U.S. Department of Labor (dol.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 1-855-950-6295 for ERISA: contact information for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-950-6295
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-950-6295
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-950-6295
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-950-6295

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 copayments $50
- Hospital (facility) copayments $800
- Other copayments $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	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$800**

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 copayments $50
- Hospital (facility) copayments $800
- Other copayments $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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

Mia's Simple Fracture

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

- The plan's overall deductible $0
- Specialist copayments $50
- Hospital (facility) copayments $800
- Other copayments $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.