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, my.centivo.com or call 1-833-201-3404. 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?	For network providers: $500 individual / $1,000 family For out-of-network providers: $5,000 individual / $10,000 family	You must pay all the costs from providers up to the deductible before this plan begins to pay. If you have other family members on the plan, Each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you have not 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?	For network providers: $3,500 individual / $7,000 family For out-of-network providers: $7,500 individual / $15,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. After you spend this amount on deductibles (including Baird's deductible contribution) and copayments, the plan pays 100%. 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, health care or pharmacy services this plan doesn't cover, and penalties for failure to obtain preauthorization.	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 1-833-201-3404 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.

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
		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	No charge, after deductible	40% coinsurance, after deductible	Virtual visits and telephonic visits are the same copay as in-office visits.
	Specialist visit	$50 copayment/visit, after deductible	40% coinsurance, after deductible	Virtual visits and telephonic visits are the same copay as in-office visits.
	Preventive care/screening /immunization	No charge	40% coinsurance, after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab Services:** No charge, after deductible **Basic Imaging:** $20 copayment/test, after deductible	40% coinsurance, after deductible	None.
	Imaging (CT/PET scans, MRIs)	$150 copayment/test, after deductible	40% coinsurance, after deductible	Preauthorization is required. If you don't get preauthorization, benefits may be reduced. Covered at 100% if performed in PCP's office or in conjunction with inpatient/outpatient admission.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.navitus.com** or call **1-866-333-2757.**	Tier 1 - Generic drugs	**Retail:** $5 copayment, after deductible **Mail Order/90 Day Retail:** $15 copayment, after deductible	Not covered	Retail copay covers up to a 30-day supply. Mail order and 90 Day Retail covers 31 to 90 day supply. $10,000 lifetime maximum for fertility medications. Specialty Medications must be coordinated through Navitus Specialty Pharmacy and filled through an in-network pharmacy. Medications may be limited to a 30-day supply.
	Tier 2 - Preferred brand drugs	**Retail:** $35 copayment, after deductible **Mail Order/90 Day Retail:** $105 copayment, after deductible	Not covered	
	Tier 3 - Non-preferred brand drugs	**Retail:** $70 copayment, after deductible **Mail Order/90 Day Retail:** $210 copayment, after deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Specialty drugs	30% coinsurance Navitus Specialty Pharmacy (up to 30-day supply)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Copayment, after deductible	40% coinsurance, after deductible	Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
	Physician/surgeon fees	$250 Copayment, after deductible	40% coinsurance, after deductible	None.
If you need immediate medical attention	Emergency room care	$200 Copayment, after deductible	$200 Copayment, after deductible	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 may be required. If preauthorization is not obtained, benefits may be reduced.
	Emergency medical transportation	$150 Copayment, after deductible	$150 Copayment, after deductible	
	Urgent care	$75 Copayment/visit, after deductible	$75 Copayment/visit, after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copayment, after deductible	40% coinsurance, after deductible	Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
	Physician/surgeon fees	**Surgeon Fee**: $500 Copayment, after deductible **Physician Fee**: No charge, after deductible	40% coinsurance, after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit**: $50 Copayment/visit, after deductible **Facility**: $250 Copayment, after deductible	**Office Visit**: $50 Copayment/visit, after deductible **Facility**: 40% coinsurance, after deductible	Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
	Inpatient services	**Surgeon Fee**: $500 Copayment, after deductible **Physician Fee**: No charge, after deductible	40% coinsurance, after deductible	
If you are pregnant	Office visits	No charge, after deductible	40% coinsurance, after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services,

Common Medical Event	Services You May Need	What You Will Pay Provider		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	**Surgeon Fee**: $500 Copayment, after deductible **Physician Fee**: No charge, after deductible	40% coinsurance, after deductible	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 facility services	$500 Copayment, after deductible	40% coinsurance, after deductible	
If you need help recovering or have other special health needs	Home health care	$50 Copayment/visit, after deductible	40% coinsurance, after deductible	Limited to 200 visits/year combined with in home private duty nursing. Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
	Rehabilitation services	$50 Copayment/visit, after deductible	40% coinsurance, after deductible	No visit limits for physical therapy, speech therapy, and occupational therapy. Preauthorization may be required after 12 visits to validate medical necessity. If preauthorization is not obtained, benefits may be reduced.
	Habilitation services	$50 Copayment/visit, after deductible	40% coinsurance, after deductible	
	Skilled nursing care	$500 Copayment, after deductible	40% coinsurance, after deductible	Limited to 120 visits/year. Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
	Durable medical equipment	**Up to $1,000 purchase price**: No charge, after deductible **$1,001 - $2,999 purchase price**: $200 Copayment, after deductible **$3,000 or more purchase price**: $400 Copayment, after deductible	40% coinsurance, after deductible	Durable medical equipment must be ordered by a physician and excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge, after deductible	40% coinsurance, after deductible	Preauthorization may be required. If preauthorization is not obtained, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage is limited to 1 vision screening each year as required by PPACA.
	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.)		
• Biofeedback • Cosmetic surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing (Inpatient) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care • Hearing Aids ($2,500 max/ear every 3 years)	• Infertility Treatment ($25,000 lifetime max) • Private Duty Nursing (Home)

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 1-833-201-3404.

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 1-833-201-3404.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-201-3404.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-201-3404.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-201-3404.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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

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	$500
Specialist copayment	$50
Hospital (facility) copayment	$500
Other coinsurance	N/A

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	$500
2025 Baird Deductible Contribution	-$500
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,520**

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) copayment	$500
Other coinsurance	N/A

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	$500
2025 Baird Deductible Contribution	-$500
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	$500
Specialist copayment	$50
Hospital (facility) copayment	$500
Other coinsurance	N/A

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	$500
2025 Baird Deductible Contribution	-$500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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