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.pivothealth.com. 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 1-877-685-2432 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 - $20,000/ individual $10,000 - $40,000/ family	Generally, you must pay all of the costs from providers up to the deductible amount 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, children's immunizations, mammograms, prostate cancer screening	This plan covers some items and services even if you haven't yet met the deductible amount. 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?	$5,000 - $20,000/ individual $10,000 - $40,000/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?	Copayments for certain services, 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?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Your Cost	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	0% coinsurance	None
	Specialist visit	0% coinsurance	None
	Preventive care/screening/ immunization	No Charge for one visit not to exceed $100	No coverage other than preventative services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain Women's Preventive Services; certain Immunizations; and certain Well Children Care.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.centuryhealthcare.com/user/login	Generic drugs	Not Covered	Not Applicable
	Preferred brand drugs	Not Covered	Not Applicable
	Non-preferred brand drugs	Not Covered	Not Applicable
	Specialty drugs	Not Covered	Not Applicable
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	None
	Physician/surgeon fees	0% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copayment/Visit then 0% Coinsurance	None
	Emergency medical transportation	0% Coinsurance	Up to $1,000 per trip for a ground conveyance and up to $2,500 per for air conveyance
	Urgent care	0% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	None
	Physician/surgeon fees	0% Coinsurance	None

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Applicable
	Inpatient services	Not Covered	Not Applicable
If you are pregnant	Office visits	Not Covered	Not Applicable
	Childbirth/delivery professional services	Not Covered	Not Applicable
	Childbirth/delivery facility services	Not Covered	Not Applicable
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	up to 40 visits per Coverage Period Coverage is limited to 1 visit per day
	Rehabilitation services	0% Coinsurance	up to $50 per day; Coverage is limited to 1 visit per day and not to exceed 20 visits combined for all therapies per Coverage Period
	Habilitation services	0% Coinsurance	up to $50 per day; Coverage is limited to 1 visit per day and not to exceed 20 visits combined for all therapies per Coverage Period
	Skilled nursing care	0% Coinsurance	Coverage is limited to 60 days of care per Coverage Period
	Durable medical equipment	0% Coinsurance	up to $2,500 per Coverage Period
	Hospice services	0% Coinsurance	Up to $15,000 per Coverage Period
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Applicable
	Children's glasses	Not covered	Not Applicable
	Children's dental check-up	Not covered	Not Applicable

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)
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Rehabilitation Services
- Services related to a mental/behavioral condition or substance abuse
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Overall Maximum Benefit per Covered Person
  $500,000, $1,000,000

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: for group health coverage subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal government group health plans, the Department of Health and Human Services, Center for Consumer Information Oversight, at 1-877-267-2323 x61565 or www.cciio.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 Health Insurance 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:1-877-685-2432.

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 888-863-1739.

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 www.pivothealth.com.

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	$5,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

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

The plan's overall deductible	$5,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,000
The total Joe would pay is	**$7,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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