
 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.centuryhealthcare.com/user/login. 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 ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes, preventive care is covered In-Network.	In Network -This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. Out-of-Network – preventive care is not covered.
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 ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. See [www.multiplan.com] or call [1-877-685-2423] 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 ?	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	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	Not covered	Not covered	Not Applicable
	Specialist visit	Not covered	Not covered	Not Applicable
	Preventive care/screening/immunization	No charge	Not covered	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)	Not covered	Not covered	Not Applicable
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
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	No charge	Not covered	Contraceptive Drugs Only – Limit of 30 day supply retail prescription.
	Preferred brand drugs	No charge	Not covered	Contraceptive Drugs Only – Limit of 30 day supply retail prescription.
	Non-preferred brand drugs	Not covered	Not covered	Not Applicable
	Specialty drugs	Not covered	Not covered	Not Applicable
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not Applicable
	Physician/surgeon fees	Not covered	Not covered	Not Applicable
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Not Applicable
	Emergency medical transportation	Not covered	Not covered	Not Applicable
	Urgent care	Not covered	Not covered	Not Applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not Applicable
	Physician/surgeon fees	Not covered	Not covered	Not Applicable

* For more information about limitations and exceptions, see the plan or policy document at [www.centuryhealthcare.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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Not Applicable
	Inpatient services	Not covered	Not covered	Not Applicable
If you are pregnant	Office visits	Not covered	Not covered	Not Applicable
	Childbirth/delivery professional services	Not covered	Not covered	Not Applicable
	Childbirth/delivery facility services	Not covered	Not covered	Not Applicable
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Not Applicable
	Rehabilitation services	Not covered	Not covered	Not Applicable
	Habilitation services	Not covered	Not covered	Not Applicable
	Skilled nursing care	Not covered	Not covered	Not Applicable
	Durable medical equipment	Not covered	Not covered	Not Applicable
	Hospice services	Not covered	Not covered	Not Applicable
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not Applicable
	Children's glasses	Not covered	Not covered	Not Applicable
	Children's dental check-up	Not covered	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](#).)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Chiropractic care • Cosmetic Surgery • Delivery and all inpatient services • Dental Care • Durable Medical Equipment • Durable Medical Equipment • Habilitation Services | <ul style="list-style-type: none"> • Home Health Care • Hospice Service • Hospital Stay, Facility Fee and Physician/Surgeon Fees • Hearing aids • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Rehabilitation Services • Private-duty nursing • Routine eye care • Routine foot care • Services related to a mental/behavioral health condition or substance abuse • Weight loss programs |
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* For more information about limitations and exceptions, see the plan or policy document at [www.centuryhealthcare.com].

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

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 [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

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 the Minimum Value Standards? No

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.*—————

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](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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](#) \$0
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$7,400
The total Joe would pay is	\$7,400

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- 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	\$1,900
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In this example, Mia would pay:

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