The Summary of Benefits and Coverage (SBC) document 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://raymondvilleisd.centivo.com/ or call 1-833-576-6491. 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 1-833-576-6491 to request a copy.

Important Questions	Answers	Why This Matters:
What is Coordinated Care?	Coordinated care means you have built a relationship with a Centivo Select Primary Care Physician (PCP) and allow the PCP to manage your care and coordinate access to other providers.	You will receive the highest level of benefits, not subject to the deductible and coinsurance, if your care is coordinated. Unless needed care is an emergency, you should always call your PCP so they can determine if they should see you or refer you to another medical provider.
What is the overall deductible?	**$0** for Coordinated Care and **$1,000** individual / **$3,000** family for Uncoordinated Care.	Generally, if your care is not coordinated, 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. No deductible applies for Coordinated care. Additionally, Telemedicine, ambulance, hospice, emergency room services, preventive care and urgent care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** individual / **$8,000** family for Coordinated Care and Uncoordinated Care. This includes prescription drugs.	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?	Any amounts outside of deductibles, copayments and coinsurance. This includes your monthly payroll contributions, penalties applicable for failure to obtain pre-certification for certain services, amounts billed by a provider above what the Plan	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	allows, and health care services this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. Coordinated Care requires that you select a Centivo Select Primary Care Physician. See https://raymondvilleisd.centivo.com or call 1-833-576-6491 for a list of Centivo Select Primary Care Physicians.	This plan uses a provider network of Primary Care Physicians. You will pay less if you select a Primary Care Physician and allow them to coordinate your care. Your selected network primary care provider will direct all of your care. This is considered coordinated care. If your Primary Care Provider is not involved in directing your care, the services are considered uncoordinated.
Do you need a referral to see a specialist?	Yes. A **referral** is required for Coordinated Care benefits, except for network OB\GYN's.	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.

Reference-Based Reimbursement (RBR)

This plan uses Reference Base Reimbursement (RBR) and has partnered with Advanced Medical Pricing Solutions (AMPS) to pay hospitals and providers what is fair and reasonable for healthcare services. RBR is a method of reimbursement based on several pricing benchmarks including Medicare, true costs and cost to charge data. You are no longer bound by in-network and out of network restrictions. For additional information visit https://raymondvilleisd.centivo.com or call Centivo Concierge Team at 833-576-6490.

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
		Coordinated Care Benefit (You will pay the least)	Uncoordinated Care Benefit (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	$35/visit Deductible does not apply	————————none————————
	Specialist visit	$25/visit	$50/visit Deductible does not apply	————————none————————
	Telemedicine Visit	$25/visit	Not Covered	————————none————————

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care Benefit (You will pay the least)	Uncoordinated Care Benefit (You will pay the most)	
	Preventive care/screening/ immunization	No charge	No charge Deductible does not apply	Services that aren't considered preventive may be subject to the non-preventive provider's office visit benefit. 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)	No charge if ordered by your Primary Care Physician; 20% coinsurance if ordered by any other provider.	20% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance after deductible	Pre-certification is required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.maxorplus.com**	Generic drugs (Tier 1)	$10/prescription (retail and mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preventive Drugs are covered at no charge (generic and single source brand only).
	Preferred brand drugs (Tier 2)	$50/prescription (retail and mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs (tier 4)	20% coinsurance	Not covered	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300/visit	20% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room care	$250/visit	$250/visit Deductible does not	Must be medically necessary to use the Emergency Room. If not an emergency, an

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care Benefit (You will pay the least)	Uncoordinated Care Benefit (You will pay the most)	
			apply	Emergency Room visit is not covered. Copayment is waived if admitted to the facility.
	Emergency medical transportation	$50 copayment	$50 copayment Deductible does not apply	Limited to $25,000 per occurrence.
	Urgent care	$25/visit	$50/visit Deductible does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/admission	20% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit	$50/visit Deductible does not apply	——————none——————
	Inpatient services	$500/admission	20% coinsurance after deductible	Pre-certification is required.
If you are pregnant	Office visits	$25/visit	$50/visit Deductible does not apply	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance after deductible	——————none——————
	Childbirth/delivery facility services	$500/admission	20% coinsurance after deductible	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care Benefit (You will pay the least)	Uncoordinated Care Benefit (You will pay the most)	
				cesarean section deliveries requiring more than a 96 hour stay.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care Benefit (You will pay the least)	Uncoordinated Care Benefit (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance after deductible	Pre-certification is required.
	Rehabilitation services	$25/visit	20% coinsurance after deductible	Pre-certification is required. Limited to 35 visits per Calendar Year combined for Cardiac and Pulmonary Therapy, Chiropractic Manipulations, Occupational Therapy, Physical Therapy, Respiratory Therapy, and Speech Therapy
	Habilitation services	$25/visit	20% coinsurance after deductible	——————none——————
	Skilled nursing care	20% coinsurance	20% coinsurance after deductible	Limited to 120 days per plan year. Pre-certification is required.
	Durable medical equipment	20% coinsurance	20% coinsurance after deductible	Pre-certification is required for purchase or rental if over $500 or if rental is greater than 2 months.
	Hospice services	No charge	No charge Deductible does not apply	Pre-certification is required for inpatient.
If your child needs dental or eye care	Children's eye exam	$25/visit	$50/visit Deductible does not apply	Services must be provided by an Ophthalmologist.
	Children's glasses	Not covered		Not covered.
	Children's dental check-up	Not covered		Not covered.

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

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 (except due to a covered surgical procedure, accident or birth defect)
- Dental care (Adult)
- Dental check-up (Child)
- Glasses (Child) (unless due to accidental injury)
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Routine Patient Costs for Clinical Trials

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

- Chiropractic care (Spinal Manipulations are limited to 35 visits per Calendar Year combined with Cardiac and Pulmonary Therapy, Occupational Therapy, Physical Therapy, Respiratory Therapy, and Speech Therapy)
- Routine eye care (Adult)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-833-576-6491. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services 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 the plan at 1-833-576-6491. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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? **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 1-833-576-6491.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-576-6491.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-576-6491.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-576-6491.

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 plan or policy document at https://raymondvilleisd.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 Coordinated pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *copayment*	$25
Hospital (facility) *copayment*	$500
Other *coinsurance*	20%

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	$540
Coinsurance	$209
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$749**

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

The plan's overall deductible	$0
Specialist *copayment*	$25
Hospital (facility) *copayment*	$500
Other *coinsurance*	20%

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	$0
Copayments	$2,710
Coinsurance	$27
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,737**

Mia's Simple Fracture
(Coordinated emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$25
Hospital (facility) *copayment*	$500
Other *coinsurance*	20%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$875
Coinsurance	$13
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$888**

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