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, visit https://hub.activisionblizzard.com/s/us-benefits or call 1-833-666-1322 or contact your Human Resources Department. 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 Coordinated Care:** $0 Individual / $0 Family **For Uncoordinated Care:** $3,000 Individual / $6,000 Family	See the Common Medical Events Chart below for your costs for services this plan covers. Coordinated Care means that you are using a network provider (or have special authorization for out-of-network providers), referrals for specialty care and have designated a Primary Care Physician through Centivo. If you do not meet the Coordinated Care requirements, your benefits will be paid at the Uncoordinated Care level. For Uncoordinated Care, you must pay all of 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?	No	This plan does not have a deductible, but a copayment or coinsurance may apply. This plan covers certain preventive services without cost sharing. 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 Coordinated Care:** $1,500 Individual / $3,000 Family **For Uncoordinated Care:** $6,000 Individual / $12,000 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, prescription drug DAW penalties*, and health care or pharmacy services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. *Prescriptions must be dispensed as written (DAW). If a generic medication exists, you will pay the difference between the generic and brand medications.
Will you pay less if you use a network provider?	Yes. See https://abk.centivo.com or call 1-833-666-1322 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. You do not need a referral for emergency services, urgent care, OB/GYN visits, behavioral health office visits, rehabilitation services, diagnostic tests, and durable medical equipment.

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 (You will pay the least)	Uncoordinated Care (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	50% coinsurance after deductible	Includes internal medicine, pediatrics, general/family practice and geriatric care. This visit includes all diagnostic tests performed by the provider during the office visit. Virtual visits and telephonic visits are covered the same as in-office visits.
	Specialist visit	No charge	50% coinsurance after deductible	A referral is required to receive specialty care at the coordinated care level. You do not need a referral for emergency services, urgent care, OB/GYN visits, behavioral health office visits, rehabilitation services, diagnostic tests, and durable medical equipment. This visit includes all diagnostic tests performed by the provider during the office visit. Virtual visits and telephonic visits are covered the same as in-office visits.
	Preventive care/screening/ immunization	No charge	50% 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)	No charge	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance after deductible	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com** or call 1-844-635-3401	Generic drugs	**Retail:** No charge **Mail Order** No charge	**Retail:** 50% coinsurance after deductible **Mail Order:** Not covered	Generic, preferred, non-preferred brand & specialty drugs: Deductible does not apply. Your plan requires that maintenance medications be filled at a 90-day supply either through mail order or at a CVS Caremark retail pharmacy. Otherwise, you will owe a $10 penalty each time you fill this medication after the 2nd time. If you or your provider choose a brand-name medication when a generic version is available, you will have to pay the brand cost sharing and the difference in cost when you fill this medication. Your plan will require you to obtain specialty medications through a CVS Caremark specialty pharmacy or you will owe the full cost of the drug when you fill this medication. Some specialty medications may be available at no cost to you through PrudentRx savings. Contact the CVS Caremark Specialty Pharmacy to learn more: (800) 237-2767
	Preferred brand drugs	**Retail:** $30 copayment **Mail Order:** $60 copayment	**Retail:** 50% coinsurance after deductible **Mail Order:** Not covered	
	Non-preferred brand drugs	**Retail:** $60 copayment **Mail Order:** $120 copayment	**Retail:** 50% coinsurance after deductible **Mail Order:** Not covered	
	Specialty drugs	**Retail (30-day) & Mail order (90-day):** Cost varies depending on drug tier	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care (You will pay the least)	Uncoordinated Care (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance after deductible	Preauthorization may be required.
	Physician/surgeon fees	No charge	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment	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.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$50 copayment/visit	$50 copayment/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance after deductible	Preauthorization may be required.
	Physician/surgeon fees	No charge	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Office visits	No charge	50% coinsurance after deductible	Preauthorization may be required for Inpatient, Residential, and Partial Day Programs.
	Outpatient services	No charge	50% coinsurance after deductible	
	Inpatient services	No charge	50% coinsurance after deductible	
If you are pregnant	Office visits	No charge	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization for childbirth is only required if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery.
	Childbirth/delivery professional services	No charge	50% coinsurance after deductible	
	Childbirth/delivery facility services	No charge	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Coordinated Care (You will pay the least)	Uncoordinated Care (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance after deductible	No limits on the number of visits per calendar year. Preauthorization may be required.
	Rehabilitation services	No charge	50% coinsurance after deductible	Limited to 90 visits per calendar year for Occupational Therapy, Physical Therapy, and Speech Therapy. You may qualify for additional visits if approval is given by your physician. Preauthorization may be required after 40 visits to validate medical necessity.
	Habilitation services	No charge	50% coinsurance after deductible	
	Skilled nursing care	No charge	50% coinsurance after deductible	No limits on the number of visits per calendar year. Preauthorization may be required.
	Durable medical equipment	No charge	50% coinsurance after deductible	Durable medical equipment must be ordered by a physician. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	50% coinsurance after deductible	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge of the contracted/permitted rate		Coverage is limited as required under PPACA.
	Children's glasses	Not covered		Children's glasses are not a covered service under this plan.
	Children's dental check-up	No charge of the contracted/permitted rate		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.)

- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- 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 (Limited to 20 visits/plan year)
- Bariatric Surgery
- Chiropractic Care (Limited to 60 visits/plan year)
- Hearing Aids (Limited to $1,500/ear every 2 years)
- Infertility Treatment (available through Kindbody)

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 1-833-666-1322. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or dol.gov/ebsa/healthreform.

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 1-833-666-1322.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-666-1322.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-666-1322.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-666-1322.

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

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

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** **$0**
- **Hospital (facility) copayment** **$0**
- **Other copayment** **$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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **Outpatient Surgical (facility) copayment** **$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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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