# 2027 Benefits Summary
# Part-Time Partners

| Plan Facts | |
|---|---|
| Carrier | Anthem |
| Website | anthem.com |
| Phone Number | 800.514.4538 |

| Cost per Weekly Paycheck | Core Value |
|---|---|
| Partner Only | $30.00 |
| Partner + Spouse | $216.90 |
| Partner + Child(ren) | $177.20 |
| Partner + Family | $364.20 |

**Tobacco-user surcharge applies to partners and their spouse who are tobacco users.

**Note**: Effective October 19, 2026, spouses with access to employer medical coverage are ineligible for Cintas medical coverage for partners hired on or after that date. Grandfathered working spouses pay a $35 per-pay-period surcharge in 2027.

| General Medical Expenses | |
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| Annual Deductible | **In Network:**<br>$3,700 Individual, applies to Single coverage only; $7,400 Family, for coverage if any combination of a spouse and/or child<br>**Out of Network: $7,400/$14,800** |
| Primary doctor office visit | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Specialist office visit | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Out-of-pocket maximum | **In Network:**<br>$3,700 Individual, applies to Single coverage only; $7,400 Family, for coverage of any combination of a spouse and/or child; includes deductible<br>**Out of Network:**<br>$10,000 Individual; $20,000 Family; as above and includes deductible |
| Lifetime Limit | Unlimited |
| **Inpatient Hospital Care** | |
| Hospital copay | Not applicable |
| Hospital semi-private room | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Inpatient lab and X-ray | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Inpatient physician and surgeon services | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| **Outpatient Care** | |
| Hospital copay | Not applicable |
| Outpatient surgery | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Outpatient laboratory services | **In Network**<br>100% covered after deductible is met; check with Plan for details<br>**Out of Network**<br>60% covered after deductible is met |
| Outpatient X-ray | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |

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| Emergency room (not followed by admission) | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>100% covered after plan deductible met (in-network deductible applies) |
| Urgent care clinic visit | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after plan deductible |
| **Prescription Drug Expenses** | |
| Vendor | CarelonRx |
| Website | www.anthem.com |
| Phone Number | 844-721-1899 |
| Retail generic | **In Network**<br>100% covered after deductible is met; 30 day supply<br>**Out of Network**<br>Not covered |
| Retail formulary brand | **In Network**<br>100% covered after deductible is met; 30 day supply<br>**Out of Network**<br>Not covered |
| Retail nonformulary brand | **In Network**<br>100% covered after deductible is met; 30 day supply<br>**Out of Network**<br>Not covered |
| Retail Specialty Rx | 100% covered after deductible is met |
| Mail order | 100% covered after deductible is met<br>90 day supply |
| Mail order Specialty Rx | 100% covered after deductible is met |
| Oral contraceptives | **In Network**<br>Retail and mail order available<br>**Out of Network**<br>Not covered |
| Rx subject to overall medical deductible & OOP | Yes |
| Annual prescription out-of-pocket maximum | Not applicable |
| Note: For coverage of weight loss medications, contact Anthem Health Guide at 800.514.4538. | |
| **Adult Preventive Care** | |
| Annual Physical Exam | **In Network:**<br>100% covered<br>**Out of Network:**<br>60% covered after deductible is met |
| Well-woman exam (includes pap) | **In Network:**<br>100% covered<br>**Out of Network:**<br>60% covered after deductible is met |
| Mammogram | **In Network:**<br>100% covered<br>**Out of Network:**<br>60% covered after deductible is met |
| Cancer screenings | **In Network:**<br>100% covered (routine)<br>**Out of Network:**<br>60% covered after deductible is met |
| Cardiovascular screenings | **In Network:**<br>100% covered (routine)<br>**Out of Network:**<br>60% covered after deductible is met |

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| **Family Planning** | |
| Fertility drugs | Covered under Prescription Drug Coverage; excluded under Medical |
| Fertility Services | **In Network:**<br>100% covered after deductible is met; limited to diagnosis and treatment of underlying cause of infertility<br>**Out of Network:**<br>60% covered; limited to diagnosis and treatment of underlying cause of infertility |
| Artificial insemination | Not covered |
| In vitro fertilization | Not covered |
| Female tubal ligation | **In Network:**<br>100% covered; reversals not covered<br>**Out of Network:**<br>60% covered after deductible, reversals not covered |
| Male vasectomy | **In Network:**<br>100% covered after deductible is met; reversals not covered<br>**Out of Network:**<br>60% covered after deductible, reversals not covered |
| **Maternity Care** | |
| Office visit:<br>Pre/postnatal | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible met |
| In-hospital delivery services | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Newborn nursery services | **In Network**<br>100% covered if baby not admitted; if admitted then 100% covered after deductible<br>**Out of Network**<br>100% covered if baby not admitted; if admitted then 60% covered after deductible |
| **Well-Baby/Well-Child Preventive Care** | |
| Pediatric exams | **In Network:**<br>100% covered<br>**Out of Network:**<br>60% covered after deductible is met |
| Immunizations (child) | **In Network:**<br>100% covered<br>**Out of Network:**<br>60% covered after deductible is met |
| **Mental Health Care** | |
| Mental Health:<br>Outpatient coverage | **In Network:**<br>100% covered after deductible is met<br>**Out of Network:**<br>60% covered after deductible is met |
| Mental Health:<br>Inpatient coverage | **In Network:**<br>100% covered after deductible is met<br>**Out of Network:**<br>60% covered after deductible is met |
| **Substance Abuse Care** | |
| Detox: Outpatient coverage | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Detox: Inpatient coverage | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Rehab: Outpatient coverage | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Rehab: Inpatient coverage | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |

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| **Dental Care** | |
| Implants | Not covered |
| Accidental injury to teeth | **In Network**<br>100% covered after deductible is met; limited to emergency care<br>**Out of Network**<br>60% covered after deductible is met; limited to emergency care |
| Surgical removal of tumors, cysts, and impacted teeth | **In Network**<br>100% covered after deductible is met; limitations apply<br>**Out of Network**<br>60% covered after deductible is met; limitations apply |
| **Vision Care** | |
| Routine vision exams | **In Network**<br>100% covered<br>**Out of Network**<br>60% covered after deductible is met |
| Regular lenses and frames | **In Network**<br>100% covered after deductible is met; limited to services following cataract surgery<br>**Out of Network**<br>60% covered; limited to services following cataract surgery |
| Contact lenses | **In Network**<br>100% covered after deductible is met; limited to services following cataract surgery<br>**Out of Network**<br>60% covered; limited to services following cataract surgery |
| **Other Services** | |
| Ambulance services | 100% covered after deductible is met |
| Allergy tests and treatments | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Durable medical equipment | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>100% covered after deductible is met |
| Smoking cessation services | Available through quit for life at 866.784.8454 or quitnow.net/Cintas |
| Weight control program | Not covered; discounts are available through WeightWatchers at ww.com/cintas |
| **Hearing Care** | |
| Hearing evaluations | **In Network**<br>100% covered<br>**Out of Network**<br>60% covered; after deductible is met |
| Hearing aids | Not covered; discounts are available through Special Offers at www.anthem.com |
| **Medical Therapy** | |
| Acupuncture | **In Network**<br>100% covered after deductible; coverage based on Anthem medical policy guidelines<br>**Out of Network**<br>100% covered after deductible; coverage based on Anthem medical policy guidelines |
| Chiropractic | **In Network**<br>100% covered after deductible is met; 30 visit annual maximum<br>**Out of Network**<br>60% covered after deductible is met; 30 visit annual maximum |
| Outpatient physical therapy | **In Network**<br>100% covered after deductible; limited to 30 visits per year; in and out-of-network combined<br>**Out of Network**<br>60% covered after deductible; limited to 30 visits per year; in and out-of-network combined |

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| Outpatient speech therapy | **In Network**<br>100% covered after deductible; limited to 30 visits per year; in and out-of-network combined<br>**Out of Network**<br>60% covered after deductible; limited to 30 visits per year; in and out-of-network combined |
| Outpatient occupational therapy | **In Network**<br>100% covered after deductible; limited to 30 visits per year; in and out-of-network combined<br>**Out of Network**<br>60% covered after deductible; limited to 30 visits per year; in and out-of-network combined |
| **Care at Alternate Sites** | |
| Noncustodial home health care | **In Network**<br>100% covered after deductible; limited to 120 visits per calendar year; in and out-of-network combined<br>**Out of Network**<br>60% covered after deductible; limited to 120 visits per calendar year; in and out-of-network combined |
| Prescribes care in noncustodial skilled nursing facility | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>60% covered after deductible is met |
| Hospice care | **In Network**<br>100% covered after deductible is met<br>**Out of Network**<br>100% covered after deductible is met (in-network deductible applies) |
| LiveHealth Online Visit | subject to deductible and out-of-pocket maximum |

*The comparison charts are compiled using information that applies to a large number of health plan users and is commonly reported by the health plans. Depending on the chart type, such as charts for dental and vision plans, certain information and/or sections won't appear because the necessary data isn't available. If you have questions about a topic that isn't covered in the charts, contact the plan's member services department for additional information. Cintas Corporation is not responsible for the accuracy of this information. If there is a discrepancy between the information displayed on these charts and the official plan documents, the official plan documents will control. Cintas Corporation reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.*