**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, call 844-798-5851 or visit join.collectivehealth.com/specialized. For 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 844-798-5851 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| **What is the overall deductible?** | For in-network services: $0<br>For out-of-network services: Not covered. | 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. In-network preventive care and certain other services are covered before you meet your deductible. Since this plan has a $0 deductible, all in-network services this plan covers will be covered when the plan begins. | 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 deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in-network services:<br>$3,500/Individual, $7,000/Family<br>For out-of-network services:<br>Not covered. | 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-billed charges, and health care this plan doesn't cover are not included. | 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?** | Yes. See join.collectivehealth.com/specialized or call 844-798-5851 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 | $20 copay/visit | Not covered | None. |
| | Specialist visit | $30 copay/visit | Not covered | None. |
| | Preventive care/screening/ immunization | No charge | Not covered | 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 | Not covered | May require prior authorization. |
| | Imaging (CT/PET scans, MRIs) | $100 copay/test | Not covered | May require prior authorization. |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available by calling Collective Health Member Advocates at 844-798-5851. | Generic drugs | Retail (30-day): $10 copay<br>Mail order (90-day): $20 copay | Retail (30-day): $10 copay<br>Mail order: Not covered | 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. In certain circumstances, you may be allotted up to 2 grace fills before owing the full cost of the drug.<br>Specialty medication is limited to a 30-day supply. |
| | Preferred brand drugs | Retail (30-day): $25 copay<br>Mail order (90-day): $50 copay | Retail (30-day): $25 copay<br>Mail order: Not covered | |
| | Non-preferred brand drugs | Retail (30-day): $45 copay<br>Mail order (90-day): $90 copay | Retail (30-day): $45 copay<br>Mail order: Not covered | |
| | Specialty drugs | Retail & Mail order (30-day): 20% coinsurance (Maximum payment of $150) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g. ambulatory surgery center) | 20% coinsurance | Not covered | Cost sharing may be greater in-network for: Imaging.<br>May require prior authorization. |

| 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) | |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Cost sharing may be greater in-network for: Imaging.<br>May require prior authorization. |
| **If you need immediate medical attention** | Emergency room care | $200 copay/visit | $200 copay/visit | Copay waived if admitted. |
| | Emergency medical transportation | $100 copay/ride | $100 copay/ride | May require prior authorization. |
| | Urgent care | $20 copay/visit | Not covered | None. |
| **If you have a hospital stay** | Facility fee (e.g. hospital room) | 20% coinsurance | Not covered | Cost sharing may be greater in-network for: Imaging.<br>May require prior authorization. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Cost sharing may be greater in-network for: Imaging.<br>May require prior authorization. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visits: $20 copay/visit<br>Intensive Outpatient: 20% coinsurance | Not covered | Intensive Outpatient:<br>May require prior authorization. |
| | Inpatient services | 20% coinsurance | Not covered | May require prior authorization. |
| **If you are pregnant** | Office visits | PCP Visits: $20 copay/visit<br>Specialist Visits: $30 copay/visit | Not covered | Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | May require prior authorization. |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | May require prior authorization. |
| **If you need help recovering or have other special needs** | Home health care | $20 copay/day | Not covered | 100 day limit every year.<br>May require prior authorization. |
| | Rehabilitation services | Physical, Occupational, & Speech Therapy: $20 copay/session | Not covered | Occupational Therapy: 24 session limit every year.<br>Chiropractic Care and Physical Therapy: Combined 30 session limit. |
| | Habilitation services | $20 copay/session | Not covered | None. |
| | Skilled nursing center | 20% coinsurance | Not covered | May require prior authorization. |

| 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) | |
| | Durable medical equipment | 20% coinsurance | Not covered | May require prior authorization. |
| | Hospice services | No charge | Not covered | May require prior authorization. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Children's eye exams are covered as required under preventive care. See vision plan for other coverage. |
| | Children's glasses | Not covered | Not covered | See vision plan for coverage. |
| | Children's dental check-up | Not covered | Not covered | See dental plan for coverage. |

## 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)
- Dental care (Child)
- Glasses (Child)
- 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 (20 session limit every year)
- Bariatric surgery
- Chiropractic care (30 session limit every year combined with Physical Therapy)
- Hearing aids ($2,500 per device limit every 3 years)
- Infertility treatment ($7,000 medical & $3,000 pharmacy lifetime limit)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, you can contact Collective Health at 844-798-5851. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.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.

For more information about limitations and exceptions, see the plan or policy document at join.collectivehealth.com/specialized.

**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 844-798-5851.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-798-5851.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-798-5851.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-798-5851.

*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 copay** **$30**
- **Hospital (facility) 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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,270** |

### 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 copay** **$30**
- **Hospital (facility) 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $700 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$920** |

### Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist copay** **$30**
- **Hospital (facility) 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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $600 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$660** |

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