
 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 833-440-4367 or visit [join.collectivehealth.com/catimes](http://join.collectivehealth.com/catimes). 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](http://www.healthcare.gov/sbc-glossary) or call 833-440-4367 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	For in- <a href="#">network</a> services: \$3,375/Individual, \$6,750/Family For out-of- <a href="#">network</a> services: \$6,750/Individual, \$13,500/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In- <a href="#">network</a> <a href="#">preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For in- <a href="#">network</a> services: \$6,750/Individual, \$13,500/Family For out-of- <a href="#">network</a> services: \$11,400/Individual, \$22,800/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, and health care this <a href="#">plan</a> doesn't cover are not included.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://join.collectivehealth.com/catimes">join.collectivehealth.com/catimes</a> or call 833-440-4367 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . Out-of-network: Subject to <a href="#">balance billing</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . Out-of-network: Subject to <a href="#">balance billing</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. In-network: <a href="#">Deductible</a> does not apply. Out-of-network: Subject to <a href="#">deductible</a> and <a href="#">balance billing</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . Out-of-network: Subject to <a href="#">balance billing</a> . May require <a href="#">prior authorization</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . Out-of-network: Subject to <a href="#">balance billing</a> . May require <a href="#">prior authorization</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available by calling Collective Health Member Advocates at 833-440-4367.	Generic drugs	Retail (30-day) & Mail order (90-day): 20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> .
	Preferred brand drugs	Retail (30-day) & Mail order (90-day): 20% <a href="#">coinsurance</a>	Not covered	Your <a href="#">plan</a> requires that maintenance medications be filled at a 90-day supply either through mail order or through participating Smart90 Walgreens Retail Locations. Otherwise, you will not be able to pick up your medication the 3rd time you fill at a retail pharmacy.
	Non-preferred brand drugs	Retail (30-day) & Mail order (90-day): 20% <a href="#">coinsurance</a>	Not covered	
	Specialty drugs	Retail (30-day) & Mail order (90-day): 50% <a href="#">coinsurance</a>	Not covered	
				If you or your <a href="#">provider</a> choose a brand-name medication when a generic version is available, you will have to pay the generic

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)	
				<p><u>cost sharing</u> and the difference in cost when you fill this medication.</p> <p>Your <u>plan</u> will require you to obtain specialty medications through Express Scripts' home delivery service (Accredo) or you will owe the full cost of the drug when you fill this medication.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g. ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Subject to in- <u>network deductible</u> .
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Subject to in- <u>network deductible</u> . May require <u>prior authorization</u> .
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g. hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Office Visits: Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Intensive Outpatient: Subject to <u>deductible</u> . Out-of- <u>network</u> : Subject to <u>balance billing</u> . May require <u>prior authorization</u> .

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)	
				Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
If you need help recovering or have other special needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . 120 day limit every year. For private duty nursing, a separate 60 day limit applies. May require <u>prior authorization</u> .
	<a href="#">Rehabilitation services</a>	Physical, Occupational, & Speech Therapy: 20% <u>coinsurance</u>	Physical, Occupational, & Speech Therapy: 40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . Occupational Therapy, Physical Therapy, and Speech Therapy: Combined 60 session limit.
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> .
	<a href="#">Skilled nursing center</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . 120 day limit every year. May require <u>prior authorization</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .

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)	
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Children's eye exams are covered as required under <u>preventive care</u> . 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Glasses (Child)</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Child)</li> <li>• Long-term care</li> <li>• Routine foot care</li> </ul>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------

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

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids (\$2,000 limit every year)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Private duty nursing (covered for home health only, 60 day limit)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>
--------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------

**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](http://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](http://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 833-440-4367. 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](http://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.

**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 833-440-4367.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-440-4367.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 833-440-4367.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-440-4367.

*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](#) **\$3,375**
- [Specialist](#) [coinsurance](#) **20%**
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

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

Cost Sharing	
Deductibles	\$3,375
Copayments	\$0
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,235</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$3,375**
- [Specialist](#) [coinsurance](#) **20%**
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$3,375
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,795</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) **\$3,375**
- [Specialist](#) [coinsurance](#) **20%**
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.