
 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 833-743-3221 or visit [join.collectivehealth.com/ensign](http://join.collectivehealth.com/ensign). 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 <https://www.healthcare.gov/sbc-glossary/> or call 833-743-3221 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For in- <u>network</u> services: \$2,000/Individual, \$4,000/Family For out-of- <u>network</u> services: Not covered.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care services are covered before you meet your <u>deductible</u> for In-Network providers.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive</u> and certain other services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>deductibles</u> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For in- <u>network</u> services: \$6,000/Individual, \$12,000/Family For out-of- <u>network</u> services: Not covered.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://join.collectivehealth.com/ensign">join.collectivehealth.com/ensign</a> or call 833-743-3221 for a list of network providers.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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>	Not covered	Subject to <a href="#">deductible</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> .
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> . May require <a href="#">prior authorization</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</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 833-743-3221.	Generic drugs	Retail (30-day): \$10 <a href="#">copay</a> Mail-order (90-day): \$20 <a href="#">copay</a>	Not covered	Subject to <a href="#">deductible</a> . 90-day supply for maintenance drugs are covered at CVS retail and mail-order only.
	Preferred brand drugs	Retail (30-day): \$25 <a href="#">copay</a> Mail-order (90-day): \$50 <a href="#">copay</a>	Not covered	Subject to <a href="#">deductible</a> . If you or your provider choose a brand name when a generic is available, you will have to pay the brand cost-sharing & the difference in cost.
	Non-preferred brand drugs	Retail (30-day): \$40 <a href="#">copay</a> Mail-order (90-day): \$80 <a href="#">copay</a>	Not covered	90-day supply for maintenance drugs are covered at CVS retail and mail-order only.
	Specialty drugs	Retail & Mail-order (30-day): 20% <a href="#">coinsurance</a> (maximum payment of \$125)	Not covered	Subject to <a href="#">deductible</a> . 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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> . May require <a href="#">prior authorization</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">deductible</a> .

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)	
				May require <u>prior authorization</u> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <u>copay</u> per visit & 30% <u>coinsurance</u>	\$500 <u>copay</u> per visit & 30% <u>coinsurance</u>	Subject to <u>deductible</u> . <u>Copay</u> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Subject to <u>deductible</u> .
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits & Outpatient: 20% <u>coinsurance</u>	Not covered	Office Visits: Subject to <u>deductible</u> . Outpatient: Subject to <u>deductible</u> . May require <u>prior authorization</u> .
	Inpatient services	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
If you are pregnant	Office visits	PCP & Specialist Visits: 20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . 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% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . 100 day limit. May require <u>prior authorization</u> .
	<a href="#">Rehabilitation services</a>	Occupational, Physical, & Speech Therapy: 20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</u> . 100 day limit. May require <u>prior authorization</u> .
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>deductible</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>	Not covered	Subject to <u>deductible</u> . May require <u>prior authorization</u> .
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered as required under preventive care.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Cosmetic surgery</li> <li>• Glasses (Child)</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Child)</li> <li>• Infertility treatment</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care (40 session limit)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot 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 1-833-743-3221. 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.

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:

For more information about limitations and exceptions, see the plan or policy document at [join.collectivehealth.com/ensign](http://join.collectivehealth.com/ensign).

Spanish (Español): Para obtener asistencia en Español, llame al 833-743-3221.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-743-3221.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 833-743-3221.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-743-3221.

—————*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](#) \$2,000
- [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>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$30
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,190</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,000
- [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>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$700
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,160</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,000
- [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>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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