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 833-834-1157 or visit join.collectivehealth.com/NortonLifeLock. 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 833-834-1157 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For in-network and out-of-network services: $1,500/Individual, $3,000/Individual + Partner, $3,000/Individual + Child(ren), $4,500/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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: $2,500/Individual, $5,000/Individual + Partner, $5,000/Individual + Child(ren), $6,850/Family For out-of-network services: $4,500/Individual, $7,500/Individual + Partner, $7,500/Individual + Child(ren), $10,500/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, the overall family out-of-pocket limit must be 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/NortonLifeLock or call 833-834-1157 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	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	None
	Specialist visit	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Deductible, then 30% coinsurance	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)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, most out-of-network services will not be covered.
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, most out-of-network services will not be covered.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available by calling Collective Health Member Advocates at 833-834-1157.	Generic drugs	Retail (30-day supply): $10 copay Retail (90-day supply): $20 copay Mail-order (90-day supply): $20 copay	Retail (30-day supply): $10 copay Retail (90-day supply): $20 copay Mail-order: Not covered.	* You must meet your deductible before the copays and coinsurance rates apply. * For medications you take regularly, after 3 fills the medication will only be covered if you get a 90-day supply, either through a Smart90 retailer or home delivery. * If you choose a brand name medication when a generic version is available, you will have to pay the generic copay and the difference in cost when you fill the medication. * You must obtain specialty medications, after the first fill, through Express Scripts' home delivery service (Accredo, or Freedom for fertility medications), or you will owe the full cost of the drug the 2nd time you fill the drug. * Injectable infertility drugs are limited to a 30-day supply with a $35 copay. Benefits for infertility medication are limited to $15000 per lifetime. * Certain limitations may apply, including prior authorization, step therapy, and quantity limits. Without prior authorization, the drugs are not covered.
	Preferred brand drugs	Retail (30-day supply): 20% coinsurance (maximum payment of $50) Retail (90-day supply): $60 copay Mail-order (90-day supply): $60 copay	Retail (30-day supply): 20% coinsurance (maximum payment of $50) Retail (90-day supply): $60 copay Mail-order: Not covered.	
	Non-preferred brand drugs	Retail (30-day supply): 30% coinsurance (maximum payment of $100) Retail (90-day supply): $130 copay Mail-order (90-day supply): $130 copay	Retail (30-day supply): 30% coinsurance (maximum payment of $100) Retail (90-day supply): $130 copay Mail-order: Not covered.	
	Specialty drugs	Retail (30-day supply): $35 copay Retail (90-day supply): Not covered Mail-order (1-30 day supply): $35 copay Mail-order (31-60 day supply): $45 copay Mail-order (61-90 day supply): $55 copay	Retail (30-day supply): $35 copay Retail (90-day supply): Not covered Mail-order: Not covered.	
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, most out-of-network services will not be covered.
	Physician/surgeon fees	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, most out-of-network services will not be covered.

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 need immediate medical attention	Emergency room care	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
	Emergency medical transportation	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
	Urgent care	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
If you have a hospital stay	Facility fee (e.g. hospital room)	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
	Physician/surgeon fees	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
	Inpatient services	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
If you are pregnant	Office visits	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	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	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
	Childbirth/delivery facility services	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
If you need help recovering or have other special needs	Home health care	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Benefits limited to 120 days per coverage period.Without prior authorization, out-of-network services will not be covered.
	Rehabilitation services	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Benefits for Occupational Therapy, Physical Therapy, and Speech Therapy limited to 180 sessions (combined) per coverage period.
	Habilitation services	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	None.
	Skilled nursing care	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Benefits limited to 90 days per coverage period. Without prior authorization, out-of-network services will not be covered.

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	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network equipment will not be covered.
	Hospice services	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance	Without prior authorization, out-of-network services will not be covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered as required under preventive care. To find out which services are considered preventive, please call a Collective Health Member Advocate at 833-834-1157.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
- Glasses (Child)
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult)
- Habilitation
- Routine eye care (Adjult)
- Dental care (Child)
- Long-term 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)
- Hearing aids (2 aids every 24 months)
- Routine foot care
- Bariatric surgery (in-network only)
- Infertility treatment (only through Progyny, coverage is limited to a lifetime maximum of 2 SMART cycles)
- Chiropractic care (20 session limit)
- Private duty nursing (covered for home health only, 120 day 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 833-834-1157. 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.

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

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:
Spanish (Español): Para obtener asistencia en Español, llame al 833-834-1157.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-834-1157.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 833-834-1157.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-834-1157.

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	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%

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	$1,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%

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	$1,500
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%

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	**$2,00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,610**

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