
 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](http://join.collectivehealth.com/NortonLifeLock). 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 833-834-1157 to request a copy.

Important Questions	Answers	Why This Matters
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>For in-<a href="#">network</a> services:                      \$350/Individual, \$700/Individual + Partner, \$700/Individual + Child(ren), \$1,050/Family                      For out-of-<a href="#">network</a> services:                      \$1,050/Individual,                      \$2,100/Individual + Partner,                      \$2,100/Individual + Child(ren),                      \$3,150/Family</p>	<p>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 <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Preventive care, hospice, and prescription drugs are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>

<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For in-<a href="#">network</a> services:            \$2,500/Individual,            \$5,000/Individual + Partner,            \$5,000/Individual + Child(ren),            \$7,500/Family</p> <p>For out-of-<a href="#">network</a> services:            \$5,350/Individual,            \$10,700/Individual + Partner,            \$10,700/Individual + Child(ren),            \$16,050/Family</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Premiums, balance-billed charges, and health care this <a href="#">plan</a> doesn't cover are not included.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://join.collectivehealth.com/NortonLifeLock">join.collectivehealth.com/NortonLifeLock</a> or call 833-834-1157 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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)	
<p><b>If you visit a health care <a href="#">provider's</a> office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>Deductible, then 15% <a href="#">coinsurance</a></p>	<p>Deductible, then 40% <a href="#">coinsurance</a></p>	<p>None</p>
	<p><a href="#">Specialist</a> visit</p>	<p>Deductible, then 15% <a href="#">coinsurance</a></p>	<p>Deductible, then 40% <a href="#">coinsurance</a></p>	<p>None</p>
	<p><a href="#">Preventive care/screening/immunization</a></p>	<p>No charge</p>	<p>Deductible, then 40% <a href="#">coinsurance</a></p>	<p>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.</p>

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 have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , most out-of-network services will not be covered.
	Imaging (CT/PET scans, MRIs)	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , most out-of-network services will not be covered.
<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 833-834-1157.	Generic drugs	Retail (30-day supply): \$10 <u>copay</u> Retail (90-day supply): \$20 <u>copay</u> Mail-order (90-day supply): \$20 <u>copay</u>	Retail (30-day supply): \$10 <u>copay</u> Retail (90-day supply): \$20 <u>copay</u> Mail-order: Not covered.	* <u>Deductible</u> does not 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.
	Preferred brand drugs	Retail (30-day supply): 25% <u>coinsurance</u> (maximum payment of \$80) Retail (90-day supply): \$75 <u>copay</u> Mail-order (90-day supply): \$75 <u>copay</u>	Retail (30-day supply): 25% <u>coinsurance</u> (maximum payment of \$80) Retail (90-day supply): \$75 <u>copay</u> Mail-order: Not covered.	* 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.
	Non-preferred brand drugs	Retail (30-day supply): 35% <u>coinsurance</u> (maximum payment of \$120) Retail (90-day supply): \$150 <u>copay</u> Mail-order (90-day supply): \$150 <u>copay</u>	Retail (30-day supply): 35% <u>coinsurance</u> (maximum payment of \$120) Retail (90-day supply): \$150 <u>copay</u> Mail-order: Not covered.	* 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.
	Specialty drugs	Retail (30-day supply): \$45 <u>copay</u> Retail (90-day supply): Not covered Mail-order (1-30 day supply): \$45 <u>copay</u> Mail-order (31-60 day supply): \$55 <u>copay</u> Mail-order (61-90 day supply): \$65 <u>copay</u>	Retail (30-day supply): \$45 <u>copay</u> Retail (90-day supply): Not covered Mail-order: Not covered.	* Injectable infertility drugs are limited to a 30-day supply with a \$45 copay. Benefits for infertility medication are limited to \$15000 per lifetime.  * Certain limitations may apply, including prior authorization, step therapy, and quantity limits. Without <u>prior authorization</u> , the drugs are not 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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g. ambulatory surgery center)	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , most out-of-network services will not be covered.
	Physician/surgeon fees	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , most out-of-network services will not be covered.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 15% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 15% <u>coinsurance</u>	None
	<a href="#">Urgent care</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 15% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g. hospital room)	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
	Physician/surgeon fees	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
	Inpatient services	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
<b>If you are pregnant</b>	Office visits	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</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	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
	Childbirth/delivery facility services	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Benefits limited to 120 days per coverage period. Without prior authorization, out-of-network services will not be covered.
	<a href="#">Rehabilitation services</a>	Deductible, then 15% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	Benefits for Occupational Therapy, Physical Therapy, and Speech Therapy limited to 180 sessions (combined) per coverage period.
	<a href="#">Habilitation services</a>	Deductible, then	Deductible, then	None.

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)	
		15% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<a href="#">Skilled nursing care</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Benefits limited to 90 days per coverage period. Without <u>prior authorization</u> , out-of-network services will not be covered.
	<a href="#">Durable medical equipment</a>	Deductible, then 15% <u>coinsurance</u>	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , some out-of-network equipment will not be covered.
	<a href="#">Hospice services</a>	No charge	Deductible, then 40% <u>coinsurance</u>	Without <u>prior authorization</u> , out-of-network services will not be covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Covered as required under <u>preventive care</u> . 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Glasses (Child)</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Habilitation</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Child)</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>
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#### 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 (20 session limit)</li> <li>• Hearing aids (2 aids every 24 months)</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery (in-network only)</li> <li>• Infertility treatment (only through Progyny, coverage is limited to a lifetime maximum of 2 SMART cycles)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (20 session limit)</li> <li>• Private duty nursing (covered for home health only, 120 day limit)</li> </ul>
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**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 833-834-1157. 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](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:**

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, kwijigo 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](#) \$350
- [Specialist](#) [coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%

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

Cost Sharing	
Deductibles	\$350
Copayments	\$10
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,220</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist](#) [coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%

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

Cost Sharing	
Deductibles	\$350
Copayments	\$100
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,470</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist](#) [coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%

#### 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>\$2,000</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$350
Copayments	\$10
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$760</b>