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 1-855-672-2692 or visit join.collectivehealth.com/bootbarn. 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 or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1650** individual / **$3300** individual +1 / **$3300** family for In-Network providers **$3000** individual / **$6000** individual +1 / **$6000** family for Out-of-Network providers	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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. See services marked "Deductible does not apply" in the Limits, Exceptions & Other Important Information column of the Common Medical Events table below.	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?	**$3500** individual / **$7000** individual +1 / **$7000** family for In-Network providers **$7000** individual / **$14000** individual +1 / **$14000** family for Out-of-Network providers	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/bootbarn** or call **1-855-672-2692** for a list of participating 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
		In-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% coinsurance	50% coinsurance	Subject to deductible for In-Network. Subject to deductible and balance billing for Out-of-network.
	Specialist visit	20% coinsurance	50% coinsurance	Subject to deductible for In-Network. Subject to deductible and balance billing for Out-of-network.
	Preventive care/screening/immunization	$0/visit	50% 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. Subject to deductible for In-Network. Subject to deductible and balance billing for Out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Subject to deductible for In-Network. May require prior authorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Subject to deductible for In-Network. May require prior authorization.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at**	Generic drugs	Retail: $10/prescription Mail Order: $20/prescription	Not covered	Subject to deductible. If you choose a brand-name medication when a generic version is available, you will have to pay the generic cost sharing and the difference in cost when you fill this medication. May require prior authorization.
	Preferred brand drugs (Formulary Drugs)	Retail: $25/prescription Mail Order: $50/prescription	Not covered	Subject to deductible. May require prior authorization.
	Non-preferred brand drugs (Non-Formulary Drugs)	Retail: $40/prescription	Not covered	Subject to deductible. May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Mail Order: $80/prescription		
	Specialty drugs	Retail: 20% coinsurance Mail Order: 20% coinsurance	Not covered	Subject to deductible. Specialty medication is limited to a 30-day supply. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Subject to in-network deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network deductible. May require prior authorization.
	Urgent care	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Inpatient services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Subject to deductible and balance billing for Out-of-network. May require prior authorization.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. 120 day limit every year. May require prior authorization.
	Rehabilitation services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Habilitation services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
	Skilled nursing care	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. 60 day limit every year. May require prior authorization
	Durable medical equipment	20% coinsurance	Not covered	Subject to deductible for In-Network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				May require prior authorization.
	Hospice services	20% coinsurance	50% coinsurance	Subject to deductible for In-Network Subject to deductible and balance billing for Out-of-network. May require prior authorization.
If your child needs dental or eye care	Children's eye exam	$0/visit	$0/visit	This cost sharing does not apply to children's eye exams covered as required under preventive care. See vision plan for other coverage. Subject to deductible for In-Network Subject to balance billing for Out-of-Network. Limit to 1 exam every year.
	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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Abortion
- Bariatric Surgery (limited to: $15,000 lifetime limit)
- Chiropractic Care (limited to: 30 session limit every year)
- Hearing Aids (limited to: I device per ear every 3 years)
- Infertility Treatment (limited to: $2,000 limit per year)
- Routine Eye Care (Adult) (1 exam limit every year)

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at . You may 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.

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 1-855-672-2692.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-672-2692.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-672-2692 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-672-2692.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-672-2692.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-672-2692.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-672-2692.

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	$1,650
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	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	$1,650
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,610**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$1,650
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	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	$1,650
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,270**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$1,650
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	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	$1,650
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**