



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, <https://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 1-855-672-2692 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | \$3300 individual / \$6600 individual +1 / \$6600 family for In-Network providers \$6600 individual / \$13200 individual +1 / \$13200 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 ? | \$8000 individual / \$16000 individual +1 / \$16000 family for In-Network providers \$16000 individual / \$32000 individual +1 / \$32000 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 https://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. |

| | | |
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| 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 | No charge | 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. May require prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | Subject to deductible. 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 (31-day): \$10/prescription (\$0 copay at Costco) Mail Order (90-day): \$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 | Retail (31-day): \$25/prescription Mail Order (90-day): \$50/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) | |
| | Non-preferred brand drugs | Retail (31-day): \$40/prescription Mail Order (90-day): \$80/prescription | Not covered | Subject to deductible. May require prior authorization. |
| | Specialty drugs | Retail & Mail order (30-day): 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 deductible for In-Network. Subject to deductible for Out-of-network. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Subject to deductible for In-Network. Subject to deductible for Out-of-network. 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. |
| | Outpatient 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) | |
| If you need mental health, behavioral health, or substance abuse services | | | | 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. Subject to deductible and balance billing for Out-of-network. May require prior authorization. |
| If you are pregnant | Office visits | 20% coinsurance | 50% coinsurance | Subject to deductible for In-Network. Subject to deductible and balance billing for Out-of-network. Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | 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. |

| 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. |
| | 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. 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 deductible and balance billing for Out-of-network. 1 exam limit 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](#).)

| | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture Cosmetic Surgery | <ul style="list-style-type: none"> Dental Care (Adult) Long Term Care Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> 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.)

| | | |
|---|---|--|
| <ul style="list-style-type: none"> • Abortion • Bariatric Surgery (limited to: \$15,000 lifetime limit) • Chiropractic Care (limited to: 30 sessions every year) | <ul style="list-style-type: none"> • Hearing Aids (limited to: 1 device per ear every 3 years) • Infertility Treatment (limited to: \$2,000 limit per year) | <ul style="list-style-type: none"> • Routine Eye Care (Adult) (limited to: 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 1-855-672-2692. 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 (Deutsch): Fer Hilf griege in Deutsch, 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, â'gang 1-855-672-2692.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo 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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|----------|---|---------|---|---------|
| ■ The plan's overall deductible | \$3,200 | ■ The plan's overall deductible | \$3,200 | ■ The plan's overall deductible | \$3,200 |
| ■ Specialist Coinsurance | 20% | ■ Specialist Coinsurance | 20% | ■ Specialist Coinsurance | 20% |
| ■ Hospital (facility) Coinsurance | 20% | ■ Hospital (facility) Coinsurance | 20% | ■ Hospital (facility) Coinsurance | 20% |
| This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$3,200 | Deductibles | \$3,200 | Deductibles | \$2,800 |
| Copayments | \$10 | Copayments | \$200 | Copayments | \$0 |
| Coinsurance | \$1,900 | Coinsurance | \$100 | Coinsurance | \$0 |
| What isn't covered | | What isn't covered | | What isn't covered | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,170 | The total Joe would pay is | \$3,520 | The total Mia would pay is | \$2,800 |