



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 833-743-3223 or visit [join.collectivehealth.com/illumina](http://join.collectivehealth.com/illumina). 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](http://www.healthcare.gov/sbc-glossary) or call 833-743-3223 to request a copy.

Important Questions	Answers	Why This Matters
<u>What is the overall deductible?</u>	For in- <u>network</u> services: \$750/Individual, \$1,500/Family For out-of- <u>network</u> services: \$1,500/Individual, \$3,000/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. In- <u>network preventive care</u> and certain other services are covered before you meet your <u>deductible</u> . See services marked "Deductible does not apply" in the Limits, Exceptions & Other Important Information column of the Common Medical Events table below.	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 certain <u>preventive services</u> 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> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	For in- <u>network</u> services: \$3,000/Individual, \$6,000/Family For out-of- <u>network</u> services: \$10,000/Individual, \$20,000/Family	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.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <u>balance-billed</u> charges, and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See join.collectivehealth.com/illumina or call 833-743-3223 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider 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 <u>referral</u> to see a <u>specialist</u> ?	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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .
	Preventive care/screening/immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> . May require <u>prior authorization</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available by calling Collective Health Member Advocates at 833-743-3223.</p>	Generic drugs	Retail (31-day): \$10 <u>copay</u> Mail order (90-day): \$20 <u>copay</u>	Retail (31-day): \$10 <u>copay</u> Mail order: Not covered	<u>Deductible</u> does not apply.
	Preferred brand drugs	Retail (31-day): \$30 <u>copay</u> Mail order (90-day): \$60 <u>copay</u>	Retail (31-day): \$30 <u>copay</u> Mail order: Not covered	If you use an out-of-network pharmacy, you may be responsible for any amount over the <u>allowed amount</u> .
	Non-preferred brand drugs	Retail (31-day): \$50 <u>copay</u> Mail order (90-day): \$100 <u>copay</u>	Retail (31-day): \$50 <u>copay</u> Mail order: Not covered	Your <u>plan</u> will require you to obtain specialty medications through a CVS/Caremark specialty pharmacy or you will owe the full cost of the drug. In certain circumstances, you may be allotted up to 2 grace fills before owing the full cost of the drug.
	<u>Specialty drugs</u>	Retail & Mail order (31-day): 30% <u>coinsurance</u>	Not covered	Specialty medication is limited to a 31-day supply.
<p>If you have outpatient surgery</p>	Facility fee (e.g. ambulatory surgery center)	Ambulatory surgery center: \$150 <u>copay/admission</u> Outpatient hospital: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Ambulatory surgery center: In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> . Outpatient hospital: Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Physician/surgeon fees	Ambulatory surgery center: \$150 <u>copay/admission</u> Outpatient hospital: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Ambulatory surgery center: In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> . Outpatient hospital: Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$250 <u>copay/visit</u>	\$250 <u>copay/visit</u>	<u>Deductible</u> does not apply. <u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Subject to in-network <u>deductible</u> . Non-emergency transportation 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)	
	Urgent care	\$40 <u>copay</u> /visit	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .
If you have a hospital stay	Facility fee (e.g. hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$30 <u>copay</u> /visit Intensive Outpatient: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Office Visits: In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .  Intensive Outpatient: Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Office visits	PCP Visits: \$30 <u>copay</u> /visit Specialist Visits: \$40 <u>copay</u> /visit	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</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> .
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</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)	
If you need help recovering or have other special needs				May require <u>prior authorization</u> .
	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . 100 day limit every year.
	<u>Rehabilitation services</u>	Physical, Occupational, & Speech Therapy: \$25 <u>copay/session</u>	Physical, Occupational, & Speech Therapy: 40% <u>coinsurance</u>	<u>Deductible</u> does not apply. Out-of-network: Subject to <u>balance billing</u> . Physical Therapy: 20 session limit every year. Occupational Therapy: 20 session limit every year. Speech Therapy: 20 session limit every year.
	<u>Habilitation services</u>	\$25 <u>copay/session</u>	40% <u>coinsurance</u>	In-network: <u>Deductible</u> does not apply. Out-of-network: Subject to <u>deductible</u> and <u>balance billing</u> .
	<u>Skilled nursing center</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . 60 day limit every year. May require <u>prior authorization</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> .
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay/exam</u>	Not covered	This <u>cost sharing</u> does not apply to children's eye exams covered as required under <u>preventive care</u> . See <u>vision plan</u> for other coverage. <u>Deductible</u> does not apply. 1 exam limit every 2 years.
	Children's glasses	Not covered	Not covered	See <u>vision plan</u> for coverage.
	Children's dental check-up	Not covered	Not covered	See <u>dental plan</u> 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.)

• Cosmetic surgery	• Dental care (Adult)	• Dental care (Child)
• Glasses (Child)	• Long-term care	• Non-emergency care when traveling outside the U.S.
• Private duty nursing	• Routine foot 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 every year)	• Bariatric surgery	• Chiropractic care (24 session limit every year)
• Hearing aids (\$2,500 per device; 1 device per ear every 3 years)	• Infertility treatment (only through Progyny)	• Routine eye care (Adult) (1 exam limit every 2 years)

**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](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), 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 833-743-3223. 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.

[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 833-743-3223.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-743-3223.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-743-3223.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-743-3223.

*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 \$750
- Specialist copay \$40
- 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>	\$12,700
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100

*What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,920</b>

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

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$750
- Specialist copay \$40
- 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>	\$5,600
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$10

*What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,580</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$750
- Specialist copay \$40
- 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>	\$2,800
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$100

*What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>