**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, contact Member Services at (855)-428-7284 or visit **www.curative.com**. 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 **https://www.healthcare.gov/sbc-glossary** or call (855)-428-7284 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **With Baseline Completion:**<br>$0 in-network.<br>$10,000 individual/ $20,000 family **out-of-network**<br>**Without Baseline Completion**:<br>$5,000 individual/$10,000 family in-network. $10,000 individual/$20,000 family **out-of-network** | Generally, you must pay all 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**.<br><br>Curative requires the completion of a Baseline Visit within 120 days of your effective date in the Curative Plan, to ensure you will pay the lowest cost (typically $0) for your **copays**, **deductible**, and **coinsurance**. The Baseline Visit is a meeting with a Curative Clinician to onboard you to the health plan and understand your health goals. The Baseline visit must be scheduled and completed within 120 calendar days of your effective date in the Curative Plan. In your first year, for the first 120 calendar days your costs will automatically align with the amounts noted for Baseline Completion, if you use a **network provider**. Reference your benefit booklet for Baseline Visit requirements at renewal.<br><br>If you do not complete the Baseline Visit within 120 days, the **copays**, **deductibles**, and **coinsurance** shown in this and the following tables for "Without Baseline Completion" will apply.<br><br>You are not required to answer health questions regarding disability or genetic information or complete medical examinations during the Baseline Visit in order to qualify as completed. |
| **Are there services covered before you meet your deductible?** | Yes. **Preventive care** and immunizations for children under the age of 6 are 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** 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/**. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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?** | **With Baseline Completion:**<br>For network providers $0 individual/ $0 family;<br>Non-Preferred Brand Name & Generic drugs and Non-preferred Specialty Drugs $7,500/ Individual & 15,000 family..<br>For out-of-network providers $15,000 individual / $30,000 family.<br>**Without Baseline Completion:**<br>For network providers $7,500 individual/ $15,000 family; for out-of-network providers $15,000 individual/ $30,000 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, 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-billing charges, health care this plan doesn't cover | 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 www.curative.com or call (855)428-7284 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<br>Network Provider (With Baseline Completion. You will pay the least) | What You Will Pay<br>Network Provider (Without Baseline Completion. You will pay more.) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $0 | $25 copay/visit | $50 copay/visit | None |
| | Specialist visit | $0 | $50 copay/visit | $100 copay/visit | None |
| | Preventive care/screening/ immunization | $0 | $0 | $50 copay for Preventive Care/Screening<br>$0 for immunizations for children under the age of 6 | 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) | $0 | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at curative.com/drugs | Preferred drugs (includes certain Generic, Brand Name & Specialty drugs | $0 | $50 copay/ prescription | 50% coinsurance | Prior authorization may be required. If you don't get prior authorization, your drug may not be covered.<br><br>*For network providers $7,500 individual/ $15,000 family. |
| | Non-preferred Brand Name & Generic drugs (annual max out-of-pocket)* | $50 copay/ prescription* | $100 copay/ prescription | 50% coinsurance | |
| | Non-preferred Specialty drugs (annual max out-of-pocket)* | $250 copay/ prescription* | 25% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (With Baseline Completion. You will pay the least) | Network Provider (Without Baseline Completion. You will pay more.) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| | Physician/surgeon fees | $0 | 20% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $0 | 20% coinsurance | 20% coinsurance | Limited to services in the United States |
| | Emergency medical transportation | $0 | 20% coinsurance | 20% coinsurance | Limited to services in the United States |
| | Urgent care | $0 | 20% coinsurance | 50% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| | Physician/surgeon fees | $0 | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Intensive Outpatient & partial hospitalization | $0 | 20% coinsurance | 50% coinsurance | Prior authorization may be required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| | Inpatient services | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (With Baseline Completion. You will pay the least) | Network Provider (Without Baseline Completion. You will pay more.) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | $0 | $25 copay/ visit (first visit only) | 50% coinsurance | None |
| | Childbirth/delivery professional services | $0 | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| If you need help recovering or have other special health needs | Home health care | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| | Rehabilitation services | $0 | 20% coinsurance | 50% coinsurance | |
| | Skilled nursing care | $0 | 20% coinsurance | 50% coinsurance | |
| | Durable medical equipment | $0 | 20% coinsurance | 50% coinsurance | Prior authorization required for equipment totaling over $750, standard manual and electric breast pumps covered up to $500. |
| | Hospice services | $0 | 20% coinsurance | 50% coinsurance | Prior authorization is required. If you don't get prior authorization, benefits could be reduced by 50% of the allowed amount of the service. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Not covered | |
| | Children's glasses | Not covered | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | |

## 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.)**

- Care outside of the United States
- Chiropractic
- Cosmetic surgery
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Routine dental care
- Routine foot care
- Routine vision 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 visits / plan year)
- Bariatric Surgery(once per lifetime)
- Hearing Aids(limits apply. See Benefit Booklet)

**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: for COBRA – U.S. Department of Labor – (866) 444-3272; for Texas state continuation – Texas Department of Insurance – (800) 252-3439. 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: Curative Member Services at (855) 428-7284.

**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 (855)-428-7284.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855)-428-7284.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (855)-428-7284.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855)-428-7284.



*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 **$5000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other 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)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $5000 |
| Copayments (1st office visit) | $25 |
| Coinsurance (20% of $7625) | $1535 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$6560** |

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible **$5000**
- Specialist copayment **$50**
- Hospital (facility) coinsurance **20%**
- Other 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)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $5000 |
| Copayments (4 office visits) | $200 |
| Coinsurance (20% of $400) | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$5280** |

### Mia's Simple Fracture

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

- The plan's overall deductible **$5000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other 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)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2800** |

Note: These numbers assume the patient has not completed their Baseline Visit. If you have completed your Baseline Visit, you will pay $0 for your Copays, Deductible, and Coinsurance for each of these examples.

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