
 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 855-429-6354 or visit join.collectivehealth.com/Rivian. 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 or call 855-429-6354 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|--|
| <p>What is the overall deductible?</p> | <p>For in-network services: \$1,000/Individual, \$3,000/Family For out-of-network services: \$2,000/Individual, \$6,000/Family</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>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.</p> | <p>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.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>For in-network services: \$3,500/Individual, \$7,500/Family For out-of-network services: \$7,000/Individual, \$15,000/Family</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billed charges, and health care this plan doesn't cover are not included.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

| | | |
|--|--|--|
| Will you pay less if you use a network provider? | Yes. See join.collectivehealth.com/Rivian or call 855-429-6354 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 | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | 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 copay /visit | 30% coinsurance | In-network: Deductible does not apply. Out-of-network: Subject to deductible and balance billing . |
| | Specialist visit | \$40 copay /visit | 30% coinsurance | In-network: Deductible does not apply. Out-of-network: Subject to deductible and balance billing . |
| | Preventive care/screening/immunization | No charge | Not covered | 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. Deductible does not apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | Subject to deductible . Out-of-network: Subject to balance billing . May require prior authorization . |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | Subject to deductible . Out-of-network: Subject to balance billing . May require prior authorization . |
| If you need drugs to treat your illness or condition More information about prescription drug | Generic drugs | Retail (30-day): \$15 copay Mail order (90-day): \$30 copay | Retail (30-day): \$15 copay & 25% coinsurance Mail order: Not covered | Generic, preferred, non-preferred brand & specialty drugs: Deductible does not apply. |
| | Preferred brand drugs | Retail (30-day): \$30 copay Mail order (90-day): \$60 copay | Retail (30-day): \$30 copay & 25% coinsurance Mail order: Not covered | If you choose a brand-name medication when a generic version is available, you will have to pay the generic cost sharing and the |

| 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) | |
| coverage is available by calling Collective Health Member Advocates at 855-429-6354. | Non-preferred brand drugs | Retail (30-day): \$60 <u>copay</u> Mail order (90-day): \$120 <u>copay</u> | Retail (30-day): \$60 <u>copay</u> & 25% <u>coinsurance</u> Mail order: Not covered | difference in cost the 3rd time you fill this medication. |
| | Specialty drugs | Retail & Mail order (90-day): Cost varies depending on drug tier | Retail (90-day): Cost varies depending on drug tier Mail order: Not covered | |
| If you have outpatient surgery | Facility fee (e.g. ambulatory surgery center) | 20% <u>coinsurance</u> | 30% <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> | 30% <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 immediate medical attention | Emergency room care | \$250 <u>copay</u> /visit | \$250 <u>copay</u> /visit | <u>Deductible</u> does not apply. <u>Copay</u> waived if admitted. |
| | Emergency medical transportation | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Subject to in-network <u>deductible</u> . |
| | Urgent care | \$50 <u>copay</u> /visit | 30% <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> | 30% <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> | 30% <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) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 <u>copay</u> /visit | 30% <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: 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> . |
| | Inpatient services | 20% <u>coinsurance</u> | 30% <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 are pregnant | Office visits | <u>PCP</u> Visits: \$20 <u>copay</u> /visit <u>Specialist</u> Visits: \$40 <u>copay</u> /visit | 30% <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> . |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 30% <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> | 30% <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 help recovering or have other special needs | Home health care | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . |
| | Rehabilitation services | Physical, Occupational, & Speech Therapy: 20% <u>coinsurance</u> | Physical, Occupational, & Speech Therapy: 30% <u>coinsurance</u> | Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . Occupational Therapy, Physical Therapy, and Speech Therapy: Combined 40 session limit. |
| | Habilitation services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Subject to <u>deductible</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) | |
| | | | | Out-of-network: Subject to <u>balance billing</u> . |
| | Skilled nursing center | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . 120 day limit every year. May require <u>prior authorization</u> . |
| | Durable medical equipment | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Subject to <u>deductible</u> . Out-of-network: Subject to <u>balance billing</u> . May require <u>prior authorization</u> . |
| | Hospice services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | <u>Deductible</u> does not apply. Out-of-network: Subject to <u>balance billing</u> . 360 day lifetime limit. May require <u>prior authorization</u> . |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Children's eye exams are covered as required under <u>preventive care</u> . See vision plan for other coverage. |
| | 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"> • Cosmetic surgery • Glasses (Child) • Private duty nursing • Weight loss programs | <ul style="list-style-type: none"> • Dental care (Adult) • Long-term care • Routine eye care (Adult) | <ul style="list-style-type: none"> • Dental care (Child) • Non-emergency care when traveling outside the U.S. • Routine foot care |
| 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"> • Acupuncture (24 session limit every year) • Hearing aids | <ul style="list-style-type: none"> • Bariatric surgery • Infertility treatment | <ul style="list-style-type: none"> • Chiropractic care (24 session 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 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 855-429-6354. 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.

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 855-429-6354.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-429-6354.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 855-429-6354.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 855-429-6354.

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](#) \$1,000
- [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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$10 |
| Coinsurance | \$2,300 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,370 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,720 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$400 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,500 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.