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, [insert contact information]. 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.[insert].com or call 1-800-[insert] to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes.</td>
<td>This plan covers items and services even if you haven’t yet met the deductible amount.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Not Applicable.</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Not Applicable.</td>
<td>This plan does not use a provider network. You can receive covered services from any provider.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Not Applicable.</td>
<td></td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
|                                            | Specialist visit                             | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).  
You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
|                                            | Preventive care/screening/immunization      | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
| If you have a test                         | Diagnostic test (x-ray, blood work)         | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
|                                            | Imaging (CT/PET scans, MRIs)                | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
| If you need drugs to treat your illness or condition | Generic drugs                               | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
|                                            | Preferred brand drugs                       | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
|                                            | Non-preferred brand drugs                  | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
|                                            | Specialty drugs                            | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
| If you have outpatient surgery             | Facility fee (e.g., ambulatory surgery center) | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).  
50% coinsurance for anesthesia. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
|                                            | Physician/surgeon fees                     | No charge  
Indian Health Care Provider (ICHP) (You will pay the least)  
No charge | Non-IHCP Provider (You will pay the most)  
No charge | |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Indian Health Care Provider (ICHP) (You will pay the least)</td>
<td>If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Non-IHCP Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>50% coinsurance for anesthesia. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge</td>
<td>If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>60 visits/year. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event

#### Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Indian Health Care Provider (ICHP)</td>
<td>Non-IHCP Provider</td>
</tr>
<tr>
<td>If you need help recovering or have other special needs</td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children's dental checkups</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

#### 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
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Weight Loss Programs

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes/No] 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/No/Not Applicable] 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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika a't'ohwol ninisingo, kwiiijgo holne' [insert telephone number].]

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** $0
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions $0

**The total Peg would pay is** $0

---

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** $0
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions $0

**The total Joe would pay is** $0

---

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The **plan's overall deductible** $0
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

Limits or exclusions $0

**The total Mia would pay is** $0

---

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