

 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 general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible		This plan covers items and services even if you haven't yet met the deductible amo
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	Not Applicable.	This plan does not have an out-of-pocket limit on y
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider	Not Applicable.	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
visit	Primary care visit to treat an injury or illness	No charge	No charge	If an out-of-network provider allowed amount , you may have to pay the difference (balance billing).	
If you visit a health care provider's office or clinic	Specialist visit	No charge	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).	
visit	Preventive care/screening/immunization	No charge	No charge	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.	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	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	No charge		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	No charge	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	No charge		
	Non-preferred brand drugs	No charge	No charge		
	Specialty drugs	No charge	No charge		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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).	
	Physician/surgeon fees	No charge	No charge	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).	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	No charge	If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).	
	Emergency medical transportation	No charge	No charge		
	Urgent care	No charge	No charge		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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).	
	Physician/surgeon fees	No charge	No charge	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).	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	If an out-of-network provider allowed amount , you may have to pay the difference (balance billing).	
	Inpatient services	No charge	No charge		
If you are pregnant	Office visits	No charge	No charge	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).	
	Childbirth/delivery professional services	No charge	No charge		
	Childbirth/delivery facility services	No charge	No charge		
If you need help recovering or have other special health needs	Home health care	No charge	No charge	60 visits/year. If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).	
	Rehabilitation services	No charge	No charge	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).	
	Habilitation services	No charge	No charge		
	Skilled nursing care	No charge	No charge	60 visits/calendar year. If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
Full	Durable medical equipment	No charge	No charge		Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
Full	Hospice services	No charge	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).
Full	Children's eye exam	No charge	No charge		Coverage limited to one exam/year. If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
If your child needs dental or eye care	Children's glasses	No charge	No charge		Coverage limited to one pair of glasses/year. If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
Full	Children's dental check-up	No charge	No charge		If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).

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 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 [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 at'ohwol ninisingo, kwijigo 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i> null	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i> null	
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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i> null	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i> null	
Limits or exclusions	\$0
The total Mia would pay is	\$0