



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.

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

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| Common Medical Event                                                                                                                                                       | Services You May Need                                  | What You Will Pay                                              |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                            |                                                        | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                   |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                     | Primary care visit to treat an injury or illness       | No charge                                                      | No charge                                    | If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                                      |
|                                                                                                                                                                            | <a href="#">Specialist</a> visit                       | No charge                                                      | No charge                                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). |
|                                                                                                                                                                            | <a href="#">Preventive care/screening/immunization</a> | No charge                                                      | No charge                                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                      |
| If you have a test                                                                                                                                                         | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                      | No charge                                    | If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                                      |
|                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                           | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a> | Generic drugs                                          | No charge                                                      | No charge                                    | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                      |
|                                                                                                                                                                            | Preferred brand drugs                                  | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                            | Non-preferred brand drugs                              | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                            | <a href="#">Specialty drugs</a>                        | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
| If you have outpatient surgery                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)         | No charge                                                      | No charge                                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). |
|                                                                                                                                                                            | Physician/surgeon fees                                 | No charge                                                      | No charge                                    | 50% <a href="#">coinsurance</a> for anesthesia. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                      |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                              |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                      | No charge                                    | If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                                      |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                      | No charge                                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). |
|                                                                           | Physician/surgeon fees                           | No charge                                                      | No charge                                    | 50% <a href="#">coinsurance</a> for anesthesia. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                      |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                                      | No charge                                    | If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                                      |
|                                                                           | 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 <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                      |
|                                                                           | 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 needs                   | <a href="#">Home health care</a>                 | No charge                                                      | No charge                                    | 60 visits/year. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                      |
|                                                                           | <a href="#">Rehabilitation services</a>          | No charge                                                      | No charge                                    | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                 |
|                                                                           | <a href="#">Habilitation services</a>            | No charge                                                      | No charge                                    |                                                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                                    | Services You May Need                     | What You Will Pay                                             |                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                         |                                           | Indian Health Care Provider (IHP)<br>(You will pay the least) | Non-IHCP Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special needs | <a href="#">Skilled nursing care</a>      | No charge                                                     | No charge                                    | 60 visits/calendar year. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                             |
|                                                         | <a href="#">Durable medical equipment</a> | No charge                                                     | No charge                                    | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                |
|                                                         | <a href="#">Hospice services</a>          | No charge                                                     | No charge                                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). |
| If your child needs dental or eye care                  | Children's eye exam                       | No charge                                                     | No charge                                    | Coverage limited to one exam/year. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                   |
|                                                         | Children's glasses                        | No charge                                                     | No charge                                    | Coverage limited to one pair of glasses/year. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                        |
|                                                         | Children's dental checkups                | No charge                                                     | No charge                                    | If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).                                                                                                                                                                      |

#### 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"> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> </ul> |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                                                                           |                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture (if prescribed for rehabilitation purposes)</li> <li>Bariatric Surgery</li> </ul>         | <ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>Weight Loss Programs</li> </ul> |

**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](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 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 at'ohwol ninisingo, kwiiijigo 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|             |     |
|-------------|-----|
| Deductibles | \$0 |
| Copayments  | \$0 |
| Coinsurance | \$0 |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |            |
|-----------------------------------|------------|
| <b>The total Peg would pay is</b> | <b>\$0</b> |
|-----------------------------------|------------|

### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|             |     |
|-------------|-----|
| Deductibles | \$0 |
| Copayments  | \$0 |
| Coinsurance | \$0 |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |            |
|-----------------------------------|------------|
| <b>The total Joe would pay is</b> | <b>\$0</b> |
|-----------------------------------|------------|

### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|             |     |
|-------------|-----|
| Deductibles | \$0 |
| Copayments  | \$0 |
| Coinsurance | \$0 |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |            |
|-----------------------------------|------------|
| <b>The total Mia would pay is</b> | <b>\$0</b> |
|-----------------------------------|------------|

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