**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 (800) 448-3585 or (928) 871-6300. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. View the Glossary at www.benefits.navajo-nsn.gov or call (800) 448-3585 or (928) 871-6300 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **Medical: $300** individual / **$600** family; per calendar year. | You must pay all costs up to the deductible amount before the plan begins to pay for covered services. Check the Plan Document to see when the deductible starts over. See the chart starting on pg. 2 for how much you pay for covered services after you meet the deductible. |
| **Are there services covered before you meet your deductible?** | Preventive Services: Medical and Dental Program<br>COVID-19 Testing during Public Health Emergency<br>COVID-19 Vaccination during Public Health Emergency<br>COVID-19 Test Kits during Public Health Emergency<br>Native Traditional Healing Benefit, Second Surgical Opinion, Vision Care Program | The plan begins to pay for covered services with no deductible amounts, co-payments, or co-insurance payments. Check the Plan Document to see the provisions that apply. |
| **Are there other deductibles for specific services?** | Yes. **Dental: $50** individual / **$150** family; per calendar year. There are no other specific deductibles. | You must pay all the costs for thee services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **Medical: $3,500** individual /**$7,000** family; per calendar year | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums; balance-billed charges; charges in excess of usual, customary and reasonable allowances; charges in excess of the maximum benefits payable under this plan; charges covered under the dental or vision care program of this plan; penalties assessed for non-compliance with the pre-certification process; charges for health care services not covered by this plan. | Although you pay these expenses, they do not count toward the out-of-pocket limit. Refer to pg. 52 of the Plan Document. |
| **Will you pay less if you use a network provider?** | Yes. Visit www.multiplan.com for a list of participating medical providers | If you use an in-network doctor or other health care provider, the plan will pay some or all of the cost of covered services. Be aware, an in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on pg. 2 for how this plan pays different types of providers. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |



[* For more information about limitations and exceptions, see the plan or policy document at www.benefits.navajo-nsn.gov.]

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% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Services or any federally funded health care providers, including referrals. |
| | Specialist visit | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Preventive care/screening/ immunization/vaccination | No Charge | May be balance billed | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Services or any federally funded health care providers, including referrals. |
| | Imaging (CT/PET scans, MRIs) | 20% after annual deductible has been met<br>Pre-Cert is required | 40% after annual deductible has been met / plus balance billing<br>Pre-Cert is required | |
| | COVID-19 virus test | No Charge | May be balance billed | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at www.medimpact.com | Generic drugs | $10 co-pay / prescription | $10 co-pay / prescription | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. |
| | Preferred brand drugs | $20 co-pay / prescription | $20 co-pay / prescription | |
| | Non-preferred brand drugs | $35 co-pay / prescription | $35 co-pay / prescription | |
| | Mail Order Benefit is available: | Generic drugs - $20 co-pay for a 90-day supply<br>Preferred brand drugs - $40 co-pay for a 90-day supply<br>Non-preferred brand drugs - $70 co-pay for a 90-day supply | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Services or any federally funded health care providers, including referrals. |
| | Physician/surgeon fees | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| **If you need immediate medical attention** | Emergency room care | 20% after $250 co-pay / visit and annual deductible has been met | 20% after $250 co-pay / visit and annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Services or any federally funded health care providers, including referrals. |
| | Emergency medical transportation | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Urgent care | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after $250 co-pay / stay and annual deductible has been met | 40% after $250 co-pay / stay and annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United |

[* For more information about limitations and exceptions, see the plan or policy document at www.benefits.navajo-nsn.gov.]

| 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) | |
| | Physician/surgeon fees | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Public Health Services or any federally funded health care providers, including referrals. Inpatient stay requires Pre-Cert. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. Inpatient stay requires Pre-Cert. |
| | Inpatient services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| **If you are pregnant** | Office visits | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. Inpatient stay requires Pre-Cert. |
| | Childbirth/delivery professional services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Childbirth/delivery facility services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| **If you need help recovering or have other special health needs** | Home Health care | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | **This Category of services requires Pre-Cert.**<br><br>Home Health limited to 400 hours per member / per calendar year.<br><br>Skilled Nursing limited to 60 days per calendar year.<br><br>Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. |
| | Rehabilitation services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Habilitation services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Skilled nursing care | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Durable medical equipment | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| | Hospice services | 20% after annual deductible has been met | 40% after annual deductible has been met / plus balance billing | |
| **If your child needs dental or eye care** | Dental check-up | Preventive – No Charge<br>Basic & Major – 20% after annual deductible has been met | Preventive – May be balance billed<br>Basic & Major – 20% after annual deductible has been met / plus balance billing | Routine dental exams 2 per calendar year. Maximum annual benefit of $2,500. Lifetime maximum benefit of $2,000 for orthodontic. |
| | | Orthodontic – 50% after annual deductible has been met | Orthodontic – 50% after annual deductible has been met / plus balance billing | Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. |

[* For more information about limitations and exceptions, see the plan or policy document at www.benefits.navajo-nsn.gov.]

| 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) | |
| | Annual Eye Exam | Amount that exceeds the annual limit $400 | Amount that exceeds the annual limit $400 / plus balance billing | Frame benefits is limited to every 12 months. Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. |
| | Glasses/Contact Lens | Amount that exceeds the annual limit $400 | Amount that exceeds the annual limit $400 / plus 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.)**

- Indian Health Service, Purchased/Referred Care referrals or other Federally Funded health care providers
- Cosmetic Surgery
- Occupational Illness or Injury
- Private Duty Nursing
- Self-Inflicted Injury
- Services that do not qualify as Medically Necessary
- TMJ Treatment
- Weight Control/Bariatric Surgery

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan Document.)**

- Hearing Loss Benefit
- Infertility/Sterility Benefit
- Native Traditional Healing Benefit
- Second Surgical Opinion
- Organ Transplants
- At-Home COVID-19 Test Kits
- Alternative Care (massage therapy, chiropractic, acupuncture, hypnotherapy, holistic and naturopathic medicines and treatment)
- Lasik Surgery Benefit

**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: New Mexico Human Services Department at www.hsd.state.nm.us or 1-888-997-2583; Arizona Department of Health Services at www.azdhs.gov or 1-602-542-1025; Department of Labor at www.dol.gov; or ISolved Benefit Services at 1-800-594-6957. 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 Document also provides 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: Navajo Nation Employee Benefits Program at 1-928-871-6300 or Verdegard Administrators, Grievance and Appeals Department at 1-800-448-3585.

**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:**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-928-871-6300

——————————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* ———————————

[* For more information about limitations and exceptions, see the plan or policy document at www.benefits.navajo-nsn.gov.]

## 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** **$300**
- **Specialist *[cost sharing-PPO]*** **20%**
- **Hospital (facility) *[cost sharing-PPO]*** **20%**
- **Other *[Inpatient Stay Co-payment]*** **$250**
- **Other *[Maximum annual OOP]*** **$3,500**

**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** | **$7,540** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments-Inpatient Stay | $250 |
| Coinsurance (**20%** up to max OOP) | $1,398 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,948** |

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

- **The plan's overall deductible** **$300**
- **Specialist *[cost sharing-PPO]*** **20%**
- **Hospital (facility) *[cost sharing-PPO]*** **20%**
- **Other *[Maximum annual OOP]*** **$3,500**

**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** | **$4,100** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance (**20%** up to max OOP) | $760 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,060** |

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

- **The plan's overall deductible** **$300**
- **Specialist *[cost sharing-PPO]*** **20%**
- **Hospital (facility) *[cost sharing-PPO]*** **20%**
- **Other *[Emerg Room Co-payment]*** **$250**
- **Other *[Maximum annual OOP]*** **$3,500**

**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** | **$21,980** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments-Emergency Room visit | $250 |
| Coinsurance (20% up to **max OOP**) | $2,950 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$3,500** |

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