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 or visit www.verdegard.com. 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 **https://www.healthcare.gov/sbc-glossary** or 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?	Participating Providers and Non-Participating Providers: **$200**/individual **$400**/family; per calendar year.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care, over the counter COVID-19 at home test kits, Native Traditional Healing Benefits, and Vision Care Program Benefits.	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/.
Are there other deductibles for specific services?	There are no specific deductibles.	You must pay all the costs for these 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?	Participating Providers and Non-Participating Providers: **$3,000**/individual **$6,000**/family; per calendar year	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.
What is not included in the out-of-pocket limit?	Premiums; balance-billing charges; charges in excess of the maximum benefits payable; charges covered under the dental or vision care program of this plan; penalties assessed for failure to obtain pre-certification; and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Please visit https://providersearch.hmatpa.com/?emp=nnebp or https://providersearch.hmatpa.com/?emp=sjipa or call 1-800-448-3585 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
		Participating Provider (You will pay the least)	Non-Participating 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
	Preventive care/screening/ immunization	Covered in Full	Covered in Full, plus balance billing	
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required. 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.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com or call (888) 648-6754	Generic drugs	$10 Copay (Retail) $20 Copay (Mail Order)	$10 Copay (Retail) $20 Copay (Mail Order)	Retail limited to a 31-day supply. Mail order limited to a 90-day supply. 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.
	Preferred brand drugs	$20 Copay (Retail) $40 Copay (Mail Order)	$20 Copay (Retail) $40 Copay (Mail Order)	
	Non-preferred brand drugs	$35 Copay (Retail) $70 Copay (Mail Order)	$35 Copay (Retail) $70 Copay (Mail Order)	
	Specialty drugs	20% Coinsurance up to $200 maximum Copay	20% Coinsurance up to $200 maximum Copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% Coinsurance after $250 Copay / visit and Annual Deductible	20% Coinsurance after $250 Copay / visit and Annual Deductible, 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
	Urgent care	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after $250 Copay / stay and Annual Deductible	40% Coinsurance after $250 Copay / stay and Annual Deductible, plus balance billing	Pre-Certification is required. 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% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required for inpatient services and partial hospitalizations. 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.
	Inpatient services	20% Coinsurance after $250 Copay / stay and Annual Deductible	40% Coinsurance after $250 Copay / stay and Annual Deductible, plus balance billing	
If you are pregnant	Office visits	20% Coinsurance After Annual Deductible	40% Coinsurance after Annual Deductible, 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.
	Childbirth/delivery professional services	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
	Childbirth/delivery facility services	20% Coinsurance after $250 Copay / stay and Annual Deductible	40% Coinsurance after $250 Copay / stay and Annual Deductible, plus balance billing	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required. Limited to 400 hours per member per calendar year. 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.verdegard.com. and www.benefits.navajo-nsn.gov.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Rehabilitation services	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required. 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.
	Habilitation services	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	
	Skilled nursing care	20% Coinsurance After Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required. Limited to 60 days per calendar year. 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.
	Durable medical equipment	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required for items that exceed $250/item. 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.
	Hospice services	20% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible, plus balance billing	Pre-Certification is required. 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.
If your child needs dental or eye care	Children's eye exam	Amount that exceeds the Annual limit of $450	Amount that exceeds the Annual limit of $450, plus balance billing	Eye exam limited to 1 per calendar year. Frames limited to 1 per calendar year. Lenses or contact lenses limited to 1 set per calendar year. 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.
	Children's glasses/Contact Lens	Amount that exceeds the Annual limit of $450	Amount that exceeds the Annual limit of $450, plus balance billing	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Children's dental check-up	**Preventive** – No Charge **Basic & Major** – 20% Coinsurance **Orthodontic** – 50% Coinsurance	**Preventive** – No Charge plus balance billing **Basic & Major** – 20% Coinsurance plus balance billing **Orthodontic** – 50% Coinsurance plus balance billing	Routine dental exams limited to 2 per calendar year. Annual Maximum benefit of $3,000. Orthodontic Lifetime Maximum benefit of $2,500. 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.

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Indian Health Service, Purchased/Referred Care referrals or other Federally Funded health care providers
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Occupational Illness or Injury
- Private Duty Nursing
- Routine foot care
- Self-Inflicted Injury
- Services that do not qualify as Medically Necessary
- TMJ Treatment
- Weight loss programs

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

- Acupuncture (limited to $1,000/year combined with all Alternative Care benefits)
- Chiropractic care (limited to $1,000/year combined with all Alternative Care benefits)
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Routine eye care (Adult)

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/ebsa; 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 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: Navajo Nation Employee Benefits Program at 1-928-871-6300 or Verdegard Administrators, LLC, 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 or 1-800-448-3585

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** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment / coinsurance** **$250 / 20%**
- **Other 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	
Deductible	$200
Copayments	$300
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment / coinsurance** **$250 / 20%**
- **Other 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	
Deductible	$200
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment / coinsurance** **$250 / 20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductible	$200
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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