



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 [harborhealthresources](#) or call Member Services at 1-855-481-0225. For general 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 <https://healthcare.gov/sbc-glossary/> or call 1-855-481-0225 to request a copy.

| Important Questions                                                             | Answers                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                          | Generally, you must pay all the costs from <a href="#">providers</a> , up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                               |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.                                                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://healthcare.gov/coverage/preventive-care-benefits/">https://healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                               |
| 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> ? | For <a href="#">network providers</a> \$10,150 individual / \$20,300 family                                                  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">HarborHealthNetwork</a> or call 1-855-481-0225 for a list of <a href="#">network providers</a> .        | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                          | You can see the <a href="#">network provider</a> / <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

 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                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | 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 visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | No Charge                                                   | \$0 <a href="#">copay</a> / visit                | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . Certain procedures performed in the office may have a <a href="#">coinsurance</a> .                                                                                                                                                                                                                                           |
|                                                                        | Harbor Health Express                                  | No Charge                                                   | \$0 <a href="#">copay</a> / visit                |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                       | No Charge                                                   | 50% <a href="#">coinsurance</a> / visit          | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . You may be able to reduce cost share, if your <a href="#">Primary Care provider</a> gives a <a href="#">referral</a> to network <a href="#">specialist</a> .                                                                                                                                                                  |
|                                                                        | <a href="#">Preventive care/screening</a> immunization | No Charge                                                   | No Charge                                        | Not Covered                                              | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay.                                                                                                                                                                                                                                                                |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . <a href="#">Diagnostic test</a> ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> .                                                                          |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . Imaging ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> . <a href="#">Prior authorization</a> is required for certain imaging or there may be no coverage. |

| 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)                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.harborhealth.com/medications">www.harborhealth.com/medications</a> | Tier 1                                         | No Charge                                                   | <b>30-Day Supply</b><br>\$10 <a href="#">copay</a> Retail<br><b>90-Day Supply</b><br>\$50 <a href="#">copay</a> Mail Order           | Not Covered                                                                      | Tier 1 drugs are available with \$0 <a href="#">copay</a> including prescribed generic contraceptives and tobacco cessation medications.<br>Certain preventive medications (including certain contraceptives) are covered at No Charge.<br>To learn more about drug tiers and about <a href="#">copays / coinsurance</a> for specific drugs, visit <a href="http://www.harborhealth.com/medications">www.harborhealth.com/medications</a><br><a href="#">Prior authorization</a> is required for certain drugs or there may be no coverage. |
|                                                                                                                                                                                                                                         | Tier 2                                         | No Charge                                                   | <b>30-Day Supply</b><br>50% <a href="#">coinsurance</a> Retail<br><b>90-Day Supply</b><br>50% <a href="#">coinsurance</a> Mail Order | Not Covered                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                         | Tier 3                                         | No Charge                                                   | <b>30-Day Supply</b><br>50% <a href="#">coinsurance</a> Retail<br><b>90-Day Supply</b><br>50% <a href="#">coinsurance</a> Mail Order | Not Covered                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                         | Tier 4 <a href="#">Specialty drugs</a>         | No Charge                                                   | <b>30-Day Supply</b><br>50% <a href="#">coinsurance</a>                                                                              | Not Covered                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center) | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                      | Not Covered                                                                      | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br>Outpatient Surgery by a <a href="#">specialist</a> that you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 coinsurance.<br><a href="#">Prior authorization</a> is required for certain services or there may be no coverage.                                                                                                                                                |
|                                                                                                                                                                                                                                         | Physician/surgeon fees                         | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                      | Not Covered                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                          | <a href="#">Emergency room care</a>            | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                      | Out of Network <a href="#">Emergency room care</a> covered as in-network benefit | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                      |

| 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)                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Out of Network <a href="#">Emergency medical transportation</a> covered as in-network | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | No Charge                                                   | \$50 <a href="#">copay</a> / visit,              | Not Covered                                                                           | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | <a href="#">Prior authorization</a> is required for certain services or there may be no coverage.                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | Mental Health Office Visit is \$0 <a href="#">copay</a> / visit. <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . Outpatient services ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> . <a href="#">Prior authorization</a> is required for certain services or there may be no coverage. |
|                                                                           | Inpatient services                               | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> . <a href="#">Prior authorization</a> is required for certain services or there may be no coverage.                                                                                                                                                                                                                                                                                                           |
| If you are pregnant                                                       | Office visits                                    | No Charge                                                   | \$0 <a href="#">copay</a> / visit,               | Not Covered                                                                           | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> in the office.                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery professional services        | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | Certain procedures performed in the office may have a <a href="#">coinsurance</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                           | Childbirth/delivery facility services            | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                                                           | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                             |

| 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 help recovering or have other special health needs | <a href="#">Home health care</a>        | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              | 60 visits / per plan year<br><a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br><a href="#">Home health care</a> ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> .                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Rehabilitation services</a> | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br><a href="#">Rehabilitation services</a> ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> .<br>Limits per plan year: Physical, Occupational, Speech, Chiropractic: combined limit 35 visits per plan year.<br>No limits apply for treatment of covered mental health or substance use disorders.<br>No limits apply for Acquired Brain Injury services. |
|                                                                | <a href="#">Habilitation services</a>   | No Charge                                                   | 50% <a href="#">coinsurance</a>                  | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br><a href="#">Habilitation services</a> ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> .<br>Limits per plan year: Physical, Occupational, Speech, Chiropractic: combined limit 35 visits per plan year.<br>No limits apply for treatment of covered mental health or substance use disorders.                                                          |

| 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) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                        | <a href="#">Skilled nursing care</a>      | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                                               | Not Covered                                              | 25 days / per plan year<br><a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                         |
|                                        | <a href="#">Durable medical equipment</a> | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                                               | Not Covered                                              | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.<br><a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br><a href="#">Prior authorization</a> is required for certain <a href="#">Durable medical equipment</a> rented or purchased over \$2,000.                                                                                                                                |
|                                        | <a href="#">Hospice services</a>          | No Charge                                                   | Home <a href="#">Hospice services</a><br>50% <a href="#">coinsurance</a><br><br>Inpatient <a href="#">Hospice services</a><br>50% <a href="#">coinsurance</a> | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .<br>Home <a href="#">Hospice services</a> ordered by <a href="#">Primary Care provider</a> or ordered by the <a href="#">specialist</a> you were referred to by your <a href="#">Primary Care provider</a> may be reduced to \$0 <a href="#">coinsurance</a> .<br><a href="#">Prior authorization</a> is required for certain services or there may be no coverage. |
| If your child needs dental or eye care | Children's eye exam                       | No Charge                                                   | \$0 <a href="#">copay</a> / visit                                                                                                                             | Not Covered                                              | Coverage limited to one exam/per plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                        | Children's glasses                        | No Charge                                                   | 50% <a href="#">coinsurance</a>                                                                                                                               | Not Covered                                              | <a href="#">Cost sharing</a> waived at non-IHCP <a href="#">network providers</a> with IHCP <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | Children's dental check-up                | No Charge                                                   | Not Covered                                                                                                                                                   | Not Covered                                              | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

## Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                      |                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion (except when life of mother at risk)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>                      | <ul style="list-style-type: none"><li>• Dental care (Adult) Infertility treatment</li><li>• Infertility Treatment</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine foot care (except with diagnosis of diabetes)</li><li>• Weight loss programs</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>• Chiropractic care</li></ul>                                                                                                                               | <ul style="list-style-type: none"><li>• Hearing aids (one pair every thirty-six months)</li></ul>                                                    | <ul style="list-style-type: none"><li>• Private-duty nursing (during inpatient stay)</li><li>• Routine eye care (Adult) (one exam per year)</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: Harbor Health at 1-855-481-0225. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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: Member service number listed on the back of your ID card or Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

## 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? 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 1-855-481-0225

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-481-0225

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-481-0225

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-481-0225

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**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 **0.02** 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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 50% |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 50% |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 50% |

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                      |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| What isn't covered                |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$60</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 50% |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 50% |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 50% |

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                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 50% |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 50% |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 50% |

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                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.