This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-201-0450

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,200 person / $2,400 family	You must pay all the costs up to the annual **deductible** amount before this plan begins to pay for the covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	None
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers: $6,450 person / $12,900 family. For non-participating providers: $12,900 person/ $25,800 family	The **out-of-pocket limit** is the most you could pay during the coverage period for your share of covered services. Non-covered services and charges above usual and customary amounts do not count towards the out-of-pocket limit.
What is not included in the out–of–pocket limit?	Premiums, Non-Covered Services/Items	Even though you pay these expenses, they don't count towards the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. Varies by State.	If you use an in-network doctor, **provider,** or facility, this plan will pay a higher percentage of your claim compared to using an out-of-network provider. Be aware, your in-network doctor or facility may use an out-of-network provider for some services.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15%	30%	None
	Specialist visit	15%	30%	None
	Other practitioner office visit	15%	30%	None
	Preventive care/screening/immunization	$0	Not Covered	Per USPSTF
If you have a test	Diagnostic test (x-ray, blood work)	20%	40%	None
	Imaging (CT/PET scans, MRIs)	20%	40%	None
If you need drugs to treat your illness or condition	Generic drugs	$10	Must Use Medco	None
	Preferred brand drugs	$30	Must Use Medco	None
	Non-preferred brand drugs	$60	Must Use Medco	None
	Specialty drugs	$60%	Must Use Medco	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15%	40%	None
	Physician/surgeon fees	15%	40%	None
If you need immediate medical attention	Emergency room services	15%	30%	Additional $50 co-pay
	Emergency medical transportation	15%	30%	$2,500 maximum per transport
	Urgent care	15%	30%	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15%	30%	None
	Physician/surgeon fee	15%	30%	None

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15%	30%	None
	Mental/Behavioral health inpatient services	15%	30%	None
	Substance use disorder outpatient services	15%	30%	None
	Substance use disorder inpatient services	15%	30%	None
If you are pregnant	Prenatal and postnatal care	15%	30%	None
	Delivery and all inpatient services	15%	30%	None
If you need help recovering or have other special health needs	Home health care	15%	30%	None
	Rehabilitation services	15%	30%	None
	Habilitation services	15%	30%	None
	Skilled nursing care	15%	30%	None
	Durable medical equipment	15%	30%	$5,000 annual limit
	Hospice service	15%	30%	None
If your child needs dental or eye care	Eye exam	$0	Not Covered	Once Annually
	Glasses	Not Covered	Not Covered	None
	Dental check-up	No Charge	No Charge	Preventive checkups covered at 100%
Other dental needs	Basic & Major Services	20% - 50%	20%-50%	Basic covered at 80%, Major 50% Annual Maximum is $1,500

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Long Term Care
- Vision
- Infertility Treatment
- Sterilization
- Breast Reduction Surgery
- Bariatric Surgery
- Weight Loss Programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and Stare laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. For more information on your rights to continue coverage, contact the plan at 1-800-201-0450.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cherokee at 800-201-0450.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,395
- **Patient pays** $2,145

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,200
Co-pays	$0
Co-insurance	$945
Limits or exclusions	$0
Total	**$2,145**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,742
- **Patient pays** $1,658

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$5,400**

Patient pays:

Deductibles	$1,200
Co-pays	$0
Co-insurance	$458
Limits or exclusions	$0
Total	**$1, 658**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.