**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, call us at (855) 827-4448. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (855) 827-4448 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| **What is the overall deductible?** | $3,000 Individual or $6,000 Family | See the Common Medical Events chart below for your costs for services this plan covers. 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. Primary Care, Specialist Care, Urgent Care, some Prescriptions Drugs, Lab and X-ray services, Pediatric Dental and Vision, Outpatient Hospital Services, and Mental Health Outpatient Services are covered before you meet you meet your deductible. | 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $7,500 Individual or $15,000 Family | 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, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See https://brighthealthplan.com/provider-finder/ifp or call 1-855-827-4448 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. |



*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_12379_20210101.pdf.

| | | |
|---|---|---|
| **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 |
|---|---|---|---|---|
| | | 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 | $35 | Not Covered | None |
| | Specialist visit | $70 | Not Covered | None |
| | Preventive care/screening/ immunization | No charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services are needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Labs: $50 per visit<br>X-rays: $100 per visit | Not Covered | Services require pre-authorization. |
| | Imaging (CT/PET scans, MRIs) | 40% | Not Covered | |
| **If you need drugs to treat your illness or condition.** More information about prescription drug coverage is available at www.brighthealthplan.com | Generic drugs (Tier 2) | $25 | Not Covered | Tier 1 drugs are Preventive medications that are of $0 cost to you.<br>Copays shown reflect the cost per retail prescription.<br>Mail Order copays are 2.5 times the Retail cost. |
| | Preferred brand drugs (Tier 3) | $150 | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | $250 | Not Covered | |
| | Specialty drugs (Tier5) | 40% | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $500 | Not Covered | Services require pre-authorization. |
| | Physician/surgeon fees | 40% | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | 40% | 40% | None |
| | Emergency medical transportation | 40% | 40% | |
| | Urgent care | $50 | $50 | |

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_12379_20210101.pdf.

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | 40% | Not Covered | Services require pre-authorization. |
| | Physician/surgeon fees | 40% | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 | Not Covered | None |
| | Inpatient services | 40% | Not Covered | Services require pre-authorization. |
| **If you are pregnant** | Office visits | No charge | Not Covered | Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization. |
| | Childbirth/delivery professional services | 40% | Not Covered | |
| | Childbirth/delivery facility services | 40% | Not Covered | |
| **If you need help recovering or have other special needs** | Home health care | 40% | Not Covered | Services require pre-authorization. Limited to 20 visits per calendar year. |
| | Rehabilitation services | 40% | Not Covered | Services require pre-authorization. Limited to 35 combined visits per year for Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic Manipulations. |
| | Habilitation services | 40% | Not Covered | Services require pre-authorization. Limited to 35 combined visits per year for Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic Manipulations. |
| | Skilled nursing center | 40% | Not Covered | Limited to 60 days per calendar year.<br>Services require pre-authorization. |
| | Durable medical equipment | 40% | Not Covered | Services require pre-authorization. |
| | Hospice services | 40% | Not Covered | Services require pre-authorization. |

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_12379_20210101.pdf.

| 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 your child needs dental or eye care** | Children's eye exam | No charge | Not Covered | Limited to 1 eye exam per calendar year through the end of the month in which the dependent child turns 19. |
| | Children's glasses | No charge | Not Covered | Limited to 1 pair of glasses, including standard frames and standard lenses or a one-year supply of contact lenses, per calendar year, through the end of the month in which they turn 19. |
| | Children's dental checkup | No charge | Not Covered | Includes diagnostic and preventive services for dependent children through the end of the month in which the dependent child turns 19. Refer to the policy for covered services and limitations. |

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_12379_20210101.pdf.

## 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.) | | |
|---|---|---|
| Abortion (except in cases of rape, incest, or when the life of the mother is endangered)<br>Acupuncture | Dental Care (Adults)<br>Hearing Aids<br>Infertility Treatment | Non-emergency care when traveling outside the U.S.<br>Private-duty nursing<br>Routine eye care (Adults) |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| Chiropractic Care | Routine foot care (for diabetes) | |

**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: Florida Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-4288, Phone No. (850) 413-3089 or (877) MY-FL-CFO (693-5236). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact us at 1-855-827-4448.

**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: Bright Health at www.brighthealthplan.com or the Florida Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399-4288, Phone No. (850) 413-3089 or (877) MY-FL-CFO (693-5236).

**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:**
Spanish (Español): Para obtener asistencia en Español, llame al (855) 827-4448.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 827-4448.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (855) 827-4448.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855) 827-4448.

***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 | $3,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $700 |
| Coinsurance | $3,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,960** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $1,000 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$4,100** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 40% |
| Other coinsurance | 40% |

**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** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,300 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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

# Dental Plan Options

Why Is Dental Coverage Important?

- Dental health is tied to your overall health.
- Routine dental exams can detect symptoms of more than 125 diseases.
- Regular checkups and cleanings can save you the pain and expense of future problems.

Plan Features:

- Florida Dental Benefits (FDB) administers the dental benefits for Bright Health. FDB is licensed by the Florida Office of Insurance Regulation. They offer dental benefits to Members throughout Florida. The company is headquartered in Miami, Florida.
- Benefits are provided through 1000+ participating dentists.
- Visit our website, BrightHealth.FDBenefits.com to find a participating dentist near you.
- Dental benefits apply only at participating dental offices.
- No deductibles or claim forms.
- Unlimited annual benefits.

| | **Adult Dental Benefits** | **Pediatric Dental Benefits** (dependent children under age 19) |
|---|---|---|
| **Plan Benefits** | Fixed copayments provide savings of 40-50% from usual and customary fees charged by dentists. | Fixed copayments provide savings of 40-50% from usual and customary fees charged by dentists. |
| **Diagnostic & Preventive Procedures** | Covered diagnostic and preventive procedures provided at no charge to Members. | Covered diagnostic and preventive procedures provided at no charge to Members. |
| **Upgraded metals for crowns** | Additional charge of up **$75 per unit.** | Additional charge of up **$75 per unit.** |
| **Lab Fees** | Additional charge of up to **$150 per crown or denture.** | Additional charge of up to **$150 per crown or denture.** |
| **Orthodontics (Braces)** | Not covered | Medically necessary orthodontia covered at fixed copayments. |
| **Specialist Services** | 25% Discount | 25% Discount |

## Comparison of the most commonly used procedures

| ADA Code | Description | Average Dentist Charge** | Member Pays | |
|---|---|---|---|---|
| | | | Adult Dental Plan | Pediatric Dental Plan |
| **Diagnostic** | | | | |
| D0120 | Periodic Oral Exam | $69 | No Charge | No Charge |
| D0140 | Limited Oral Evaluation - Problem Focused | $37 | No Charge | No Charge |
| D0150 | Comprehensive Oral Evaluation, Once Per 12 months | $30 | No Charge | No Charge |
| **X-Rays** | | | | |
| D0210 | Intraoral Complete Series, Once Per 3 Years | $110 | No Charge | No Charge |
| D0220 | Periapical First Film | $26 | No Charge | No Charge |
| D0230 | Periapical Each Additional Film | $28 | No Charge | No Charge |
| D0270 | Bitewing - Single Film, Once Per Year | $54 | No Charge | No Charge |
| D0272 | Bitewings - Two Films, Once Per Year | $54 | No Charge | No Charge |
| D0330 | Panoramic X-Rays, Once Per 3 Years | $100 | No Charge | No Charge |
| **Preventive** | | | | |
| D1110 | Routine Adult Prophylaxis, Once Per 6 Months | $52 | No Charge | No Charge |
| D1120 | Routine Child Prophylaxis, Once Per 6 Months | $30 | Not Covered | No Charge |
| D1208 | Topcal Application Of Fluoride | $15 | Not Covered | No Charge |
| **Restorative Fillings** | | | | |
| D2330 | Resin - 1 Surface, Anterior | $152 | $50 | $50 |
| D2331 | Resin - 2 Surfaces, Anterior | $178 | $55 | $55 |
| D2332 | Resin - 3 Surfaces, Anterior | $208 | $65 | $65 |
| **Fixed Crown And Bridge** | | | | |
| D2750 | Crown - Porcelain Fused To High Noble Metal* | $1,509 | $690 | $690 |
| **Endodontics (Root Canals)** | | | | |
| D3310 | Root Canal - Anterior | $797 | $160 | $160 |
| D3320 | Root Canal - Bicuspid | $890 | $275 | $275 |
| **Periodontics (Gum Treatment)** | | | | |
| D4341 | Periodontal Scaling And Root Planing, Per Quadrant | $225 | $60 | $60 |
| D4355 | Full Mouth Debridement | $251 | $65 | $65 |
| **Oral Surgery (Extractions)** | | | | |
| D7140 | Extraction Erupted Or Exposed Tooth | $161 | $30 | $30 |
| D7210 | Surgical extraction, erupted tooth | $264 | $55 | $55 |
| D7220 | Soft tissue impaction | $350 | $70 | $70 |
| D7230 | Partial bony impaction | $446 | $90 | $90 |
| **Orthodontics (Braces)** | | | | |
| D8080 | Comprehensive orthodontic treatment - child | $4,938 | Not Covered | $2,800 |
| D8090 | Comprehensive orthodontic treatment - adult | $5,130 | Not Covered | $3,200 |

* Includes additional charges for lab fees and noble, high noble and titanium metals

**Average Dentist Charges are based on average fees charged by dentists in Florida.