**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?** | $0 Med/$4,950 Rx Individual or<br>$0 Med/$9,900 Rx 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, Specialty Care, Outpatient Mental Health, Urgent Care, Emergency Room, Lab and X-ray services, Imaging (CT/MRI/PET scan), Inpatient Hospital, Outpatient Hospital, Outpatient Surgery, PT/OT/ST, some Prescription Drugs, and Pediatric Dental and Vision are covered before the 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?** | $8,550 Individual or<br>$17,100 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. |



*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_16985_20210101.pdf.

| | | |
|---|---|---|
| **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. |
| **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 | $50 per visit | Not Covered | None |
| | Specialist visit | $100 per visit | Not Covered | None |
| | Preventive care/screening/ immunization | No charge | No Charge | 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) | $300 per visit | 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) | $30 per prescription | 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) | $200 per prescription | Not Covered | |
| | Non-preferred brand drugs (Tier 4) | 50% per prescription | Not Covered | |
| | Specialty drugs (Tier5) | 50% per prescription | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $1,000 per visit | Not Covered | None |
| | Physician/surgeon fees | $300 | Not Covered | |
| **If you need immediate** | Emergency room care | $1,000 per visit | $1,000 per visit | None |

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_16985_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) | |
| **medical attention** | Emergency medical transportation | 50% | 50% | |
| | Urgent care | $50 per visit | $50 per visit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $2,500 per day up to 2 days | Not Covered | None |
| | Physician/surgeon fees | $300 | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 per visit | Not Covered | None |
| | Inpatient services | $2,500 per day up to 2 days | 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 | $2,500 per day up to 2 days | Not Covered | |
| | Childbirth/delivery facility services | $2,500 per day up to 2 days | Not Covered | |
| **If you need help recovering or have other special needs** | Home health care | 50% | Not Covered | Limited to 60 visits per calendar year.<br>Services require pre-authorization. |
| | Rehabilitation services | $100 per visit | Not Covered | Limited to 30 habilitative and 30 rehabilitative visits per calendar year combined between speech, occupational, and physical therapy.<br>Services require pre-authorization. |
| | Habilitation services | $100 per visit | Not Covered | Limited to 30 habilitative and 30 rehabilitative visits per calendar year combined between speech, occupational, and physical therapy.<br>Services require pre-authorization. |
| | Skilled nursing center | $2,500 per day up to 2 days | Not Covered | Limited to 60 days per calendar year.<br>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_16985_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) | |
| | Durable medical equipment | 50% | Not Covered | Services require pre-authorization. |
| | Hospice services | 50% | Not Covered | Services require pre-authorization. |
| **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 lenses or a one-year supply of contact lenses, per calendar year, through the end of the month in which the dependent child turns 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. |

## 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 | Private-duty Nursing<br>Routine eye care (Adults)<br>Routine foot care |

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact the State Insurance Department, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x.61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_16985_20210101.pdf.

**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 (855) 827-4448.

**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.***

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_16985_20210101.pdf.

## 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 $0 Med/$4,950 Rx
- Specialist Copay $100 per visit
- Hospital (facility) Coinsurance $2,500 per day up to 2 days
- Other coinsurance 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*)

| **Total Example Cost** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $6000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6060** |

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

- The plan's overall deductible $0 Med/$4,950 Rx
- Specialist Copay $100 per visit
- Hospital (facility) Coinsurance $2,500 per day up to 2 days
- Other coinsurance 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*)

| **Total Example Cost** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $3100 |
| Copayments | $900 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$4420** |

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

- The plan's overall deductible $0 Med/$4,950 Rx
- Specialist Copay $100 per visit
- Hospital (facility) Coinsurance $2,500 per day up to 2 days
- Other coinsurance 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*)

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1100 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1900** |

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