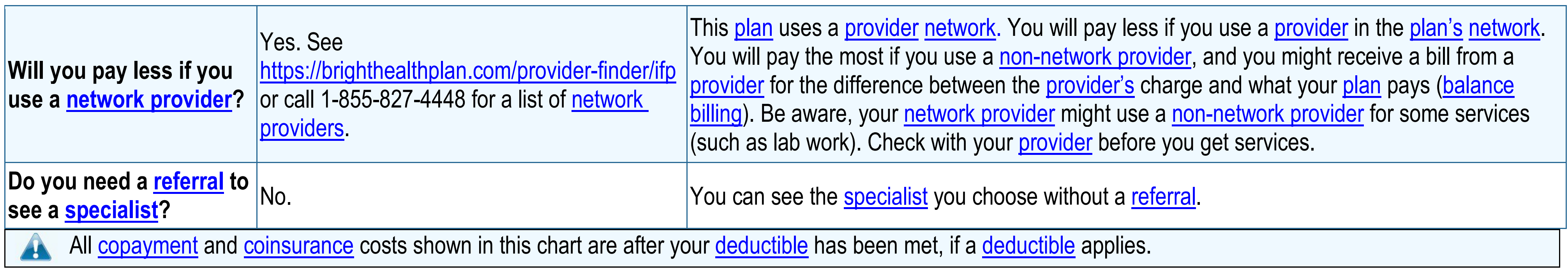
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at (855) 827-4448 or visit https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_40463_20210101.pdf. 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?	For Network Providers: $1,000 Individual or $2,000 Family For Non-Network Providers: $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, Emergency Care, some Prescription Drugs, Lab and X-ray, Pediatric Dental and Vision, 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?	For Network Providers: $8,550 Individual or $17,100 Family For Non-Network Providers: None	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 a non-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 a non-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)	Non-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	No charge for the first two visits, then $20 copay/visit. Deductible does not apply.	50% coinsurance	None
	Specialist visit	$40 copay/visit. Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge. Deductible does not apply.	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 copay/visit. Deductible does not apply. X-ray: $100 copay/visit. Deductible does not apply.	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Services require pre-authorization.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at	Generic drugs (Tier 2)	Retail: $15 copay/ prescription. Mail Order: $37.50 copay/ prescription. Deductible does not apply.	50% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
www.brighthealthplan.com	Preferred brand drugs (Tier 3)	Retail: $50 copay/ prescription. Mail Order: $125 copay/ prescription. Deductible does not apply.	50% coinsurance	Some prescription drugs may require authorization.
	Non-preferred brand drugs (Tier 4)	Retail: $125 copay/ prescription. Mail Order: $312.50 copay/ prescription. Deductible does not apply.	50% coinsurance	
	Specialty drugs (Tier5)	Retail: 20% coinsurance Mail Order: 20% coinsurance	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$500 copay/visit. Deductible does not apply.	$500 copay/visit. Deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit. Deductible does not apply.	$50 copay/visit. Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health,	Outpatient services	$20 copay/visit. Deductible does not apply.	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
or substance abuse services	Inpatient services	20% coinsurance	50% coinsurance	Services require pre-authorization.
If you are pregnant	Office visits	No charge. Deductible does not apply.	50% coinsurance	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special needs	Home health care	20% coinsurance	50% coinsurance	Services require pre-authorization. Limited to 30 visits per calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Services require pre-authorization. Limited to 25 combined visits per year for Occupational Therapy, Physical Therapy, and Speech Therapy.
	Habilitation services	20% coinsurance	50% coinsurance	Services require pre-authorization. Limited to 25 combined visits per year for Occupational Therapy, Physical Therapy, and Speech Therapy.
	Skilled nursing center	20% coinsurance	50% coinsurance	Services require pre-authorization. Limited to 30 days per calendar year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Services require pre-authorization.
	Hospice services	20% coinsurance	50% coinsurance	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	Limited to 1 eye exam per calendar year through the end of the month in which the member turns 19.
	Children's glasses	No charge up to the provider's contracted amount. Deductible does not apply.	50% coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Children's dental checkup	No charge. Deductible does not apply.	50% coinsurance	Includes diagnostic and preventive services through the end of the month in which the member 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_40463_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) Acupuncture Bariatric Surgery	Cosmetic Surgery Dental Care (Adults) Infertility Treatment Long Term Care	Non-emergency care when traveling outside the U.S. Routine eye care (Adults) Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Chiropractic Care	Hearing Aids (limited to one hearing aid per hearing impaired ear every 4 years and up to four (4) additional ear molds)	Private-duty nursing (limited to 85 visits per calendar year 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: Bright Health at 1-855-827-4448; the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; and Healthcare.gov at http://www.HealthCare.gov, or call 1-800-318-2596. 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.

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 contact the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071.

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_40463_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 $1,000
- Specialist copayment $40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

- The plan's overall deductible $1,000
- Specialist copayment $40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

- The plan's overall deductible $1,000
- Specialist copayment $40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	$1,000
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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