




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](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
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">Network Providers</a> : \$5,900 Individual or \$11,800 Family For <a href="#">Non-Network Providers</a> : \$17,700 Individual or \$35,400 Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. Generally, you must pay all of 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Primary Care, <a href="#">Urgent Care</a> , some <a href="#">Prescription Drugs</a> , and Pediatric Dental and Vision are covered before you meet your <a href="#">deductible</a> .	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 <a href="#">plan</a> 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://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">Network Providers</a> : \$8,550 Individual or \$17,100 Family For <a href="#">Non-Network Providers</a> : None	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://brighthousehealthplan.com/provider-finder/ifp">https://brighthousehealthplan.com/provider-finder/ifp</a> or call 1-855-827-4448 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 a <a href="#">non-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 a <a href="#">non-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
 All <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge. <a href="#">Deductible</a> does not apply.	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services are needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Labs: 40% <a href="#">coinsurance</a> X-ray: 40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
<b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at	Generic drugs (Tier 2)	Retail: \$25 <a href="#">copay</a> /prescription. Mail Order: \$62.50 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). <a href="#">Copay</a> shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [https://cdn1.brighthousehealthplan.com/docs/2021\\_COCs/COC\\_40463\\_20210101.pdf](https://cdn1.brighthousehealthplan.com/docs/2021_COCs/COC_40463_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)	Non-Network Provider (You will pay the most)	
<a href="http://www.brighthealthplan.com">www.brighthealthplan.com</a>	Preferred brand drugs (Tier 3)	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some <a href="#">prescription drugs</a> may require authorization.
	Non-preferred brand drugs (Tier 4)	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a> (Tier5)	Retail: 40% <a href="#">coinsurance</a> Mail Order: 40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health,	Outpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None

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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)	
<b>or substance abuse services</b>	Inpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
<b>If you are pregnant</b>	Office visits	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require <a href="#">pre-authorization</a> .
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> . Limited to 30 visits per calendar year.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> . Limited to 25 combined visits per year for Occupational Therapy, Physical Therapy, and Speech Therapy.
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> . Limited to 25 combined visits per year for Occupational Therapy, Physical Therapy, and Speech Therapy.
	<a href="#">Skilled nursing center</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> . Limited to 30 days per calendar year.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Services require <a href="#">pre-authorization</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	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. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	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.

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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. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Includes diagnostic and <a href="#">preventive services</a> through the end of the month in which the member turns 19. Refer to the policy for covered services and limitations.

## Excluded Services & Other Covered Services

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
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 <a href="#">plan</a> 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](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: Bright Health at [www.brighthealthplan.com](http://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, kwijigo 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](#) \$5,900
- [Specialist coinsurance](#) 40%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,660</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,900
- [Specialist coinsurance](#) 40%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$4,300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,620</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,900
- [Specialist coinsurance](#) 40%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,810</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.