



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 <a href="#">deductible</a> ?                                | \$5,000 – Individual or<br>\$10,000 – 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> .                              |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Specialist Visit, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, X-rays and Diagnostic Imaging, Outpatient Facility Fee, Urgent Care Centers or Facilities, Outpatient - Mental/Behavioral Health Services Office, Prenatal and Postnatal Care, Child - Routine Eye Exam, Child - Eye Glasses, Child - Dental Check-Up | 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> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                                                                                                                                                                                                    | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,700 – Individual or<br>\$17,400 – Family                                                                                                                                                                                                                                                                                                                          | 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.                                                                                                                                                                                                                                                                                       |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.brighthealthcare.com/search">www.brighthealthcare.com/search</a> or call (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 an <a href="#">out-of-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 an <a href="#">out-of-network provider</a> for some services                 |

|                                                                              |    |                                                                                            |
|------------------------------------------------------------------------------|----|--------------------------------------------------------------------------------------------|
|                                                                              |    | (such as lab work). Check with your <a href="#">provider</a> before you get services.      |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(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       | No charge for first 3 visit(s) then \$40     | Not Covered                                        | Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay.                                                                                                                                                                  |
|                                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                       | \$80                                         | Not Covered                                        | None                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                          | <a href="#">Preventive care/screening/immunization</a> | No Charge                                    | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive, then check what Your plan will pay for and what Your cost will be.                                                                                 |
| <b>If you have a test</b>                                                                                                                                                                                                | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Lab: \$50<br>X-ray: \$100                    | Not Covered                                        | None                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                           | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition.</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.brighthealthcare.com">www.brighthealthcare.com</a> | Preferred generic drugs                                | \$0/\$30                                     | Not Covered                                        | Preventive Care medications are provided at \$0 cost to You, regardless of tier.<br>Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription).<br>Copays shown reflect the cost per retail prescription.                          |
|                                                                                                                                                                                                                          | Preferred brand drugs and Non-preferred generics       | \$150                                        | Not Covered                                        |                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                          | Non-preferred brand drugs and Non-preferred generics   | \$250                                        | Not Covered                                        |                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                        | 40% after Deductible                         | Not Covered                                        |                                                                                                                                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center)         | \$500                                        | Not Covered                                        | Services require Prior Authorization.                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                          | Physician/surgeon fees                                 | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                                                           | <a href="#">Emergency room care</a>                    | 40% after Deductible                         | 40% after Deductible                               | This cost does not apply if You are admitted directly to the hospital for inpatient services. If a <a href="#">Non-Network Provider</a> charges more than Our <a href="#">Allowed Amount</a> , You may have to pay the difference ( <a href="#">balance billing</a> ). |
|                                                                                                                                                                                                                          | <a href="#">Emergency medical transportation</a>       | 40% after Deductible                         | 40% after Deductible                               | None                                                                                                                                                                                                                                                                   |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                 |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                        |
|                                                                                  | <a href="#">Urgent care</a>               | \$50                                         | \$50                                               | None                                                                                                                                   |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                  |
|                                                                                  | Physician/surgeon fees                    | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$0                                          | Not Covered                                        | Services require Prior Authorization.                                                                                                  |
|                                                                                  | Inpatient services                        | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                  |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$0                                          | Not Covered                                        | None                                                                                                                                   |
|                                                                                  | Childbirth/delivery professional services | 40% after Deductible                         | Not Covered                                        | Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization. None           |
|                                                                                  | Childbirth/delivery facility services     | 40% after Deductible                         | Not Covered                                        |                                                                                                                                        |
| <b>If you need help recovering or have other special needs</b>                   | <a href="#">Home health care</a>          | 40% after Deductible                         | Not Covered                                        | Limited to 60 Visit(s) per Year. Services require Prior Authorization.                                                                 |
|                                                                                  | <a href="#">Rehabilitation services</a>   | 40% after Deductible                         | Not Covered                                        | Limited to 30 Visit(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization. |
|                                                                                  | <a href="#">Habilitation services</a>     | 40% after Deductible                         | Not Covered                                        | Limited to 30 Visit(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization. |
|                                                                                  | <a href="#">Skilled nursing center</a>    | 40% after Deductible                         | Not Covered                                        | Limited to 60 Days per Year. Services require Prior Authorization.                                                                     |
|                                                                                  | <a href="#">Durable medical equipment</a> | 40% after Deductible                         | Not Covered                                        | Services require Prior Authorization.                                                                                                  |
|                                                                                  | <a href="#">Hospice services</a>          | 40% after Deductible                         | Not Covered                                        | Limited to 6 Months per Episode. Services require Prior Authorization.                                                                 |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$0                                          | Not Covered                                        | Limited to 1 eye exam per calendar year, through the end of the month in which the dependent child turns 19.                           |

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                     |
|----------------------|----------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                            |
|                      | Children's glasses         | \$0                                          | 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 the dependent child turns 19. |
|                      | Children's dental checkups | \$0                                          | Not Covered                                        | Includes diagnostic and preventive services 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 <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)<br>Cosmetic Surgery<br>Infertility Treatment<br>Private-Duty Nursing<br>Weight Loss Programs | Acupuncture<br>Dental Care (Adults)<br>Long-Term Care<br>Routine Eye Care (Adults) | Bariatric Surgery<br>Hearing Aids<br>Non-emergency care when traveling outside the U.S.<br>Routine Foot Care |
| 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                                                                                                                                                                     |                                                                                    |                                                                                                              |

**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](http://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](http://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 [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 HealthCare 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, 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](#) \$5,000
- [Specialist](#) copayment \$80
- Hospital (facility) co-insurance 40%
- Other co-insurance 40%

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

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

In this example, Peg would pay:

| Cost Sharing                |        |
|-----------------------------|--------|
| <a href="#">Deductibles</a> | \$5000 |
| <a href="#">Copayments</a>  | \$700  |
| <a href="#">Coinsurance</a> | \$2400 |
| What isn't covered          |        |
| Limits or exclusions        | \$60   |
| The total Peg would pay is  | \$8160 |

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) copayment \$80
- Hospital (facility) co-insurance 40%
- Other co-insurance 40%

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

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

In this example, Joe would pay:

| Cost Sharing                |        |
|-----------------------------|--------|
| <a href="#">Deductibles</a> | \$3900 |
| <a href="#">Copayments</a>  | \$500  |
| <a href="#">Coinsurance</a> | \$0    |
| 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](#) \$5,000
- [Specialist](#) copayment \$80
- Hospital (facility) co-insurance 40%
- Other co-insurance 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                |        |
|-----------------------------|--------|
| <a href="#">Deductibles</a> | \$2300 |
| <a href="#">Copayments</a>  | \$400  |
| <a href="#">Coinsurance</a> | \$0    |
| What isn't covered          |        |
| Limits or exclusions        | \$0    |
| The total Mia would pay is  | \$2700 |