



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  |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or<br>\$1,000 – Individual or<br>\$2,000 – 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> .                              |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Primary Care Visit to Treat an Injury or Illness, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, X-rays and Diagnostic Imaging, Emergency Room Services, 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> . |
| <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> | \$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.   |
| <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="http://www.brighthousehealthcare.com/search">www.brighthousehealthcare.com/search</a> or call (855) 827-4448 for a list of network providers. | 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. |
| <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 [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   |
|---|--|--|---|---|--|
|   |  | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP 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  | \$0   | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Telehealth services are available. Refer to Your Schedule of Benefits to determine what You will pay.                               |
|   | <a href="#">Specialist</a> visit                       | No charge  | No charge for first 2 visit(s) then \$40            | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge  | No Charge   | Not Covered   | 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 and what Your cost will be. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge  | Lab: \$50<br>X-ray: \$100                           | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|   | Imaging (CT/PET scans, MRIs)                           | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization.  |
| <b>If you need drugs to treat your illness or condition.</b>                  | Generic drugs  | No charge  | \$0/\$15  | Not Covered   |  |
|   | Preferred brand drugs                                  | No charge  | \$50  | Not Covered   |  |

| Common Medical Event   | Services You May Need                            | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information   |
|--|--|--|---|---|--|
|  |  | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |  |
| More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.brighthealthcare.com">www.brighthealthcare.com</a> | Non-preferred brand drugs                        | No charge  | \$125   | Not Covered   | Preventive medications are covered at \$0 cost to you. Some generic drugs may also be available for \$0. Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Copays shown reflect the cost per retail prescription. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |
|  | <a href="#">Specialty drugs</a>                  | No charge  | 20% after Deductible                                | Not Covered   |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | Physician/surgeon fees                           | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
| <b>If you need immediate medical attention</b>   | <a href="#">Emergency room care</a>              | No charge  | \$500   | \$500   | This cost does not apply if You are admitted directly to the hospital for inpatient services. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | <a href="#">Emergency medical transportation</a> | No charge  | 20% after Deductible                                | 20% after Deductible  | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | <a href="#">Urgent care</a>                      | No charge  | \$50  | \$50  | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|---|---|--|
|  |   | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |  |
|  | Physician/surgeon fees                    | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | No charge  | \$0   | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | Inpatient services                        | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
| <b>If you are pregnant</b>   | Office visits                             | No charge  | \$0   | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | Childbirth/delivery professional services | No charge  | 20% after Deductible                                | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization.                               |
|  | Childbirth/delivery facility services     | No charge  | 20% after Deductible                                | Not Covered   |  |
| <b>If you need help recovering or have other special needs</b>                   | <a href="#">Home health care</a>          | No charge  | 20% after Deductible                                | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | <a href="#">Rehabilitation services</a>   | No charge  | 20% after Deductible                                | Not Covered   | Limited to 30 Visit(s) per Year. Visits combined for physical, occupational therapy, and chiropractic services. Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |

| Common Medical Event                   | Services You May Need                     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|---|
|  |   | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Habilitation services</a>     | No charge  | 20% after Deductible                                | Not Covered   | Limited to 30 Visit(s) per Year. Visits combined for physical, occupational therapy, and chiropractic services. Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .  |
|  | <a href="#">Skilled nursing center</a>    | No charge  | 20% after Deductible                                | Not Covered   | Limited to 60 Days per Year. Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .   |
|  | <a href="#">Durable medical equipment</a> | No charge  | 20% after Deductible                                | Not Covered   | Services require Prior Authorization. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .  |
|  | <a href="#">Hospice services</a>          | No charge  | 20% after Deductible                                | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .  |
| If your child needs dental or eye care | Children's eye exam                       | No charge  | \$0   | Not Covered   | Limited to 1 eye exam per calendar year through the end of the month in which the dependent child turns 19. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .  |
|  | Children's glasses                        | No charge  | \$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. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |

| Common Medical Event | Services You May Need     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information  |
|----------------------|---------------------------|--|---|---|---|
|                      |                           | Indian Health Care Provider (IHCP)<br>(You will pay the least) | Non-IHCP In-Network Provider<br>(You will pay more) | Non-IHCP Out-of-Network Provider<br>(You will pay the most) |   |
|                      | Children's dental checkup | No charge  | \$0   | Not Covered   | Includes diagnostic and preventive services for members up to the end of the month in which the member turns 19. Refer to the policy for covered services and limitations. <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . |

## 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>Dental Care (Adults)<br>Routine Eye Care (Adults)                                     | Acupuncture<br>Long-Term Care<br>Routine Foot Care | Cosmetic Surgery<br>Non-emergency care when traveling outside the U.S.<br>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.) |   |              |
|--|---|--------------|
| Bariatric Surgery<br>Infertility Treatment   | Chiropractic Care<br>Private-Duty Nursing | Hearing Aids |

**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 North Carolina Insurance Consumer Assistance Program at [www.ncdoi.gov/consumers/health-insurance](http://www.ncdoi.gov/consumers/health-insurance) or 1-855-408-1212. Other coverage options may be available to you too, including buying individual insurance coverage through Healthcare.gov. For more information about Healthcare.gov, 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 [www.brighthealthcare.com](http://www.brighthealthcare.com) or contact the North Carolina Insurance Consumer Assistance Program at [www.ncdoi.gov/consumers/health-insurance](http://www.ncdoi.gov/consumers/health-insurance) or 1-855-408-1212.

### 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ▪ <a href="#">Specialist</a> copayment                          | \$40    |
| ▪ Hospital (facility) co-insurance                              | 20%     |
| ▪ Other co-insurance  | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |               |
|-----------------------------------|---------------|
| <a href="#">Deductibles</a>       | \$1000        |
| <a href="#">Copayments</a>        | \$700         |
| <a href="#">Coinsurance</a>       | \$2000        |
| What isn't covered                |               |
| Limits or exclusions              | \$60          |
| <b>The total Peg would pay is</b> | <b>\$3760</b> |

### Managing Joe's Type 2 Diabetes

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

|   |         |
|---|---------|
| ▪ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ▪ <a href="#">Specialist</a> copayment                          | \$40    |
| ▪ Hospital (facility) co-insurance                              | 20%     |
| ▪ Other co-insurance  | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |               |
|-----------------------------------|---------------|
| <a href="#">Deductibles</a>       | \$1000        |
| <a href="#">Copayments</a>        | \$1200        |
| <a href="#">Coinsurance</a>       | \$100         |
| What isn't covered                |               |
| Limits or exclusions              | \$20          |
| <b>The total Joe would pay is</b> | <b>\$2320</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ▪ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ▪ <a href="#">Specialist</a> copayment                          | \$40    |
| ▪ Hospital (facility) co-insurance                              | 20%     |
| ▪ Other co-insurance  | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |               |
|-----------------------------------|---------------|
| <a href="#">Deductibles</a>       | \$1000        |
| <a href="#">Copayments</a>        | \$600         |
| <a href="#">Coinsurance</a>       | \$200         |
| What isn't covered                |               |
| Limits or exclusions              | \$0           |
| <b>The total Mia would pay is</b> | <b>\$1800</b> |

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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