Coverage Period: 01/01/2022 - 12/31/2022 Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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?	\$6,700 – Individual or \$13,400 – Family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Primary Care Visit to Treat an Injury or Illness, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, X- rays and Diagnostic Imaging, Outpatient Facility Fee, Outpatient Surgery Physician/Surgical 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 <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$8,700 – Individual or \$17,400 – Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See www.brighthealthcare.com/search or call	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a

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	providers.	<u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$0	Not Covered	Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay.
	<u>Specialist</u> visit	No charge for first 2 visit(s) then \$75	Not Covered	None
	Preventive care/screening/ immunization	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$50 X-ray: \$100	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% after Deductible	Not Covered	Services require Prior Authorization.
If you need drugs to treat	Preferred generic drugs	\$0	Not Covered	
More information about	Preferred brand drugs and Non- preferred generics	\$90	Not Covered	Preventive Care medications are provided at \$0 cost to You, regardless of tier.
prescription drug coverage is available at www.brighthealthcare.com	Non-preferred brand drugs and Non-preferred generics	\$150	Not Covered	Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Copays shown reflect the cost per retail prescription.
www.brighthealthcare.com	Specialty drugs	40% after Deductible	Not Covered	oopayo shoriin ronost ano sost por rotam prosonipasiii
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$900	Not Covered	Services require Prior Authorization.
	Physician/surgeon fees	\$400	Not Covered	Services require Prior Authorization.
If you need immediate medical attention	Emergency room care	40% after Deductible	40% after Deductible	This cost does not apply if You are admitted directly to the hospital for inpatient services.

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		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Emergency medical transportation	40% after Deductible	40% after Deductible	None	
	Urgent care	\$50	\$50	None	
If you have a hospital	Facility fee (e.g., hospital room)	40% after Deductible	Not Covered	Services require Prior Authorization.	
stay	Physician/surgeon fees	40% after Deductible	Not Covered	Services require Prior Authorization.	
If you need mental health,	Outpatient services	\$0	Not Covered	Services require Prior Authorization.	
behavioral health, or substance abuse services	Inpatient services	40% after Deductible	Not Covered	Services require Prior Authorization.	
	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		
	Home health care	40% after Deductible	Not Covered	None	
	Rehabilitation services	40% after Deductible	Not Covered	Limited to 30 Visit(s) per Year. Visits combined for physical, occupational therapy, and chiropractic services. Services require Prior Authorization.	
special needs	Habilitation services	40% after Deductible	Not Covered	Limited to 30 Visit(s) per Year. Visits combined for physical, occupational therapy, and chiropractic services. Services require Prior Authorization.	
	Skilled nursing center	40% after Deductible	Not Covered	Limited to 60 Days per Year. Services require Prior Authorization.	
	Durable medical equipment	40% after Deductible	Not Covered	Services require Prior Authorization.	
	Hospice services	40% after Deductible	Not Covered	None	
If your child needs dental or eye care	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.	

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		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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.

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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	Acupuncture	Cosmetic Surgery	
life of the mother is endangered)	Non-emergency care when traveling outside the U.S.	Routine Foot Care	
Long-Term Care			
Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
Bariatric Surgery	Chiropractic Care	Dental Care (Adults)	
Hearing Aids	Infertility Treatment	Private-Duty Nursing	
Routine Eye Care (Adults)	•	•	

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 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 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 or contact the North Carolina Insurance Consumer Assistance Program at 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, kwiijigo holne' (855) 827-4448.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$6,700
Specialist copayment	\$75
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

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In this example, Peg would pay:			
Cost Sharing			
<u>Deductibles</u>	\$6700		
Copayments	\$1100		
Coinsurance	\$900		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$8760		

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,700
Specialist copayment	\$75
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

Total Example Cost

Durable medical equipment (glucose meter)

In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$3900	
<u>Copayments</u>	\$300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is \$422		

\$5,600

Mia's Simple Fracture

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

The plan's overall deductible	\$6,700
Specialist copayment	\$75
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)

<u>Durable medical equipment</u> (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800

In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$2300
<u>Copayments</u>	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2600

\$12,700