**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 deductible?** | $0 – Individual or<br>$0 – Family | See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Primary Care Visit to Treat an Injury or Illness, Specialist Visit, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, X-rays and Diagnostic Imaging, Imaging (CT/PET Scans, MRIs), Outpatient Facility Fee, Outpatient Surgery Physician/Surgical Services, Emergency Room Services, Urgent Care Centers or Facilities, Outpatient - Mental/Behavioral Health Services Office, Prenatal and Postnatal Care, Outpatient Rehabilitation Services, Habilitation Services, Child - Routine Eye Exam, Child - Eye Glasses, Child - Dental Check-Up | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $900 – Individual or<br>$1,800 – Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

* For more information about limitations and exceptions, see the plan or policy document at https://cdn.bhgplatforms.io/docs/2022_COCs/COC_44522_20220101.pdf

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.brighthealthcare.com/search or call (855) 827-4448 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $0 | Not Covered | Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay. |
| | Specialist visit | $5 | 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** | Diagnostic test (x-ray, blood work) | Lab: $5<br>X-ray: $10 | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $50 | Not Covered | Services require Prior Authorization. |
| **If you need drugs to treat your illness or condition.** More information about prescription drug coverage is available at www.brighthealthcare.com | Preferred generic drugs | $0 | 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 | $25 | Not Covered | |
| | Non-preferred brand drugs and Non-preferred generics | $50 | Not Covered | |
| | Specialty drugs | 10% | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $200 | Not Covered | Services require Prior Authorization. |
| | Physician/surgeon fees | $50 | Not Covered | Services require Prior Authorization. |
| **If you need immediate medical attention** | Emergency room care | $200 | $200 | This cost does not apply if You are admitted directly to the hospital for inpatient services. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Emergency medical transportation | 10% | 10% | None |
| | Urgent care | $5 | $5 | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% | Not Covered | Services require Prior Authorization. |
| | Physician/surgeon fees | 10% | Not Covered | Services require Prior Authorization. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $0 | Not Covered | Services require Prior Authorization. |
| | Inpatient services | 10% | Not Covered | Services require Prior Authorization. |
| **If you are pregnant** | Office visits | $0 | Not Covered | None |
| | Childbirth/delivery professional services | 10% | Not Covered | Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization. 48 hours for vaginal birth; 96 hours for cesarean delivery |
| | Childbirth/delivery facility services | 10% | Not Covered | |
| **If you need help recovering or have other special needs** | Home health care | 10% | Not Covered | None |
| | Rehabilitation services | $10 | Not Covered | Limited to 60 Visit(s) per year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization. |
| | Habilitation services | $10 | Not Covered | Limited to 60 Visit(s) per year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization. |
| | Skilled nursing center | 10% | Not Covered | None |
| | Durable medical equipment | 10% | Not Covered | Services require Prior Authorization. |
| | Hospice services | 10% | 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| Acupuncture | Cosmetic Surgery | Dental Care (Adults) |
| Long-Term Care | Non-emergency care when traveling outside the U.S. | Routine Eye Care (Adults) |
| Routine Foot Care | Weight Loss Programs | |

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

**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 Illinois Department of Insurance at 1-877-527-9431. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact us at (855) 827-4448.

**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 Illinois Department of Insurance at 1-877-527-9431.

**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.*

## 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 $0
- Specialist copayment $5
- Hospital (facility) co-insurance 10%
- Other co-insurance 10%

**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* | |
|---|---|
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$960** |

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

- The plan's overall deductible $0
- Specialist copayment $5
- Hospital (facility) co-insurance 10%
- Other co-insurance 10%

**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* | |
|---|---|
| Deductibles | $0 |
| Copayments | $900 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$970** |

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

- The plan's overall deductible $0
- Specialist copayment $5
- Hospital (facility) co-insurance 10%
- Other co-insurance 10%

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |

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