



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://brighthousehealthcare.com> or call (855) 827-4448 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	\$0 Individual or \$0 Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All covered services 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> .
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> ?	\$8,200 Individual or \$16,400 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> 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://brighthousehealthcare.com/search">https://brighthousehealthcare.com/search</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 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> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.brighthousehealthcare.com>.



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Specialist</a> visit	\$65 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply.	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Labs - \$40 <a href="#">copay</a> per test; <a href="#">deductible</a> does not apply. X-rays - \$75 <a href="#">copay</a> per test; <a href="#">deductible</a> does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="https://brighthousehealthcare.com">https://brighthousehealthcare.com</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> per prescription; <a href="#">deductible</a> does not apply.	Not Covered	Copay shown is for a 30-day supply. You can receive up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Mail order copay is 2.5 times the retail copay when a 90 day supply is received.
	Preferred brand drugs (Tier 2)	\$55 <a href="#">copay</a> per prescription; <a href="#">deductible</a> does not apply.	Not Covered	<a href="#">Pre-authorization</a> may be required, or services not covered. <a href="#">Cost sharing</a> for any prescription drugs obtained through the use of a discount card or coupon provided by a prescription drug manufacturer will not apply toward any <a href="#">deductible</a> or the <a href="#">out-of-pocket limit</a> .
	Non-preferred brand drugs (Tier 3)	\$80 <a href="#">copay</a> per prescription; <a href="#">deductible</a> does not apply.	Not Covered	<a href="#">Cost Sharing</a> for covered prescription drugs is limited to be no more than the pharmacy's retail price.

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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)	Out-of-Network Provider (You will pay)	
	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance</a> up to \$250 per prescription; <a href="#">deductible</a> does not apply.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services may require <a href="#">pre-authorization</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services may require <a href="#">pre-authorization</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	\$350 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	<a href="#">Copay</a> is waived if you are admitted.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copay</a> per trip; <a href="#">deductible</a> does not apply.	\$250 <a href="#">copay</a> per trip; <a href="#">deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	Services may require <a href="#">pre-authorization</a> .
	Inpatient services	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
If you are pregnant	Office visits	No charge	Not Covered	None
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require <a href="#">pre-</a>

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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)	Out-of-Network Provider (You will pay)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	<a href="#">authorization</a> .
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Limited to 100 visits per calendar year for Home Health and Private-duty nursing. Services require <a href="#">pre-authorization</a> .
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply.	Not Covered	Services require <a href="#">pre-authorization</a> .
	<a href="#">Skilled nursing center</a>	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Limited to 100 days per calendar year. Services require <a href="#">pre-authorization</a> .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply.	Not Covered	Services may require <a href="#">pre-authorization</a> .
	<a href="#">Hospice services</a>	No charge; <a href="#">deductible</a> does not apply.	Not Covered	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.	Not Covered
Children's glasses		No charge; <a href="#">deductible</a> does not apply.	Not Covered	Limited to 1 pair of glasses including standard frames and standard lenses, or a one-year supply of contact lenses through the end of the month in which the member turns 19.
Children's dental checkups		No charge; <a href="#">deductible</a> does not apply.	Not Covered	Includes diagnostic and preventive services through the end of the month in which the member turns 19. Refer to the policy for covered services and limitations.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.brighthousehealthcare.com>.

## 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> .)		
<ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adults)</li><li>• Routine foot care, unless medically necessary for diabetes</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li></ul>	<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (combined with Home Health)</li><li>• Routine foot care (for diabetes)</li></ul>

**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: Department of Managed Health Care at 1 (888) 466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov), and Covered California at 1 (800) 300-1506 or [coveredca.com](http://coveredca.com). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit <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: Department of Managed Health Care at 1 (888) 466-2219 or <https://www.dmhc.ca.gov/>.

### 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? Not Applicable

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.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.brighthousehealthcare.com>.

## 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](#) \$65
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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*)

<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>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,860</b>

### 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](#) \$65
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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*)

<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>	\$0
<a href="#">Copayments</a>	\$2,000
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,220</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$65
- Hospital (facility) [copayment](#) \$350
- Other [copayment](#) \$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>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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

SUBJECT TO REGULATORY APPROVAL