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

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 Individual or $0 Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All covered services are covered before you meet your deductible.	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?	$8,200 Individual or $16,400 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 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 network provider?	Yes. See https://brighthealthcare.com/search or call 1-855-827-4448 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.

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* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.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
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	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	No charge	$35 copay per visit; deductible does not apply.	Not Covered	None
	Specialist visit	No charge	$65 copay per visit; deductible does not apply.	Not Covered	None
	Preventive care/screening/ immunization	No charge	No charge; deductible does not apply.	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Labs - $40 copay per test; deductible does not apply. X-rays - $75 copay per test; deductible does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services require pre-authorization.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at https://brighthealthcare.com	Generic drugs (Tier 1)	No charge	$15 copay per prescription; deductible 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. Pre-authorization may be required, or services not covered. Cost sharing 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 deductible or the out-of-pocket limit.
	Preferred brand drugs (Tier 2)	No charge	$55 copay per prescription; deductible does not apply.	Not Covered	
	Non-preferred brand drugs (Tier 3)	No charge	$80 copay per prescription; deductible does not apply.	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	No charge	20% coinsurance up to $250 per prescription; deductible does not apply.	Not Covered	Cost Sharing for covered prescription drugs is limited to be no more than the pharmacy's retail price
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services may require pre-authorization.
	Physician/surgeon fees	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services may require pre-authorization.
If you need immediate medical attention	Emergency room care	No charge	$350 copay per visit; deductible does not apply.	$350 copay per visit; deductible does not apply.	Copay is waived if you are admitted.
	Emergency medical transportation	No charge	$250 copay per trip; deductible does not apply.	$250 copay per trip; deductible does not apply.	None
	Urgent care	No charge	$35 copay per visit; deductible does not apply.	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services require pre-authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$35 copay per visit; deductible does not apply.	Not Covered	Services may require pre-authorization.
	Inpatient services	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	No charge	No charge	Not Covered	None
	Childbirth/delivery professional services	No charge	20% coinsurance; deductible does not apply.	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery

* For more information about limitations and exceptions, see the plan or policy document at https://www.brighthealthcare.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	20% coinsurance; deductible does not apply.	Not Covered	require pre-authorization.
If you need help recovering or have other special needs	Home health care	No charge	20% coinsurance; deductible does not apply.	Not Covered	Limited to 100 visits per calendar year for Home Health and Private-duty nursing. Services require pre-authorization.
	Rehabilitation services	No charge	$35 copay per visit; deductible does not apply.	Not Covered	Services require pre-authorization.
	Habilitation services	No charge	$35 copay per visit; deductible does not apply.	Not Covered	Services require pre-authorization.
	Skilled nursing center	No charge	20% coinsurance; deductible does not apply.	Not Covered	Limited to 100 days per calendar year. Services require pre-authorization.
	Durable medical equipment	No charge	20% coinsurance; deductible does not apply.	Not Covered	Services may require pre-authorization.
	Hospice services	No charge	No charge; deductible does not apply.	Not Covered	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	No charge	No charge; deductible does not apply.	Not Covered	Limited to 1 eye exam per calendar year, through the end of the month in which the dependent child turns 19.
	Children's glasses	No charge	No charge; deductible 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	No charge; deductible 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.brighthealthcare.com.

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.)		
• Chiropractic Care • Cosmetic Surgery • Dental Care (Adult)	• Hearing Aids • Long Term Care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adults) • Routine foot care, unless medically necessary for diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture	• Bariatric Surgery • Infertility treatment	• Private-duty nursing (combined with Home Health) • Routine foot care (for diabetes)

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, and Covered California at 1 (800) 300-1506 or 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, kwiijigo 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.brighthealthcare.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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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