



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>\$6,700 – Individual or<br>\$13,400 – 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, 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 <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 \$75            | 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  | 40% 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   | Not Covered   |  |
|   | Preferred brand drugs                                  | No charge  | \$90  | 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  | \$150   | 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  | 40% after Deductible                                | Not Covered   |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | No charge  | \$900   | 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  | \$400   | 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  | 40% after Deductible                                | 40% after Deductible  | 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  | 40% after Deductible                                | 40% 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  | 40% 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) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |   |
|  | Physician/surgeon fees                    | No charge   | 40% 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   | 40% 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   | 40% 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   | 40% after Deductible                             | Not Covered  |   |
| <b>If you need help recovering or have other special needs</b>                   | <a href="#">Home health care</a>          | No charge   | 40% 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="#">Rehabilitation services</a>   | No charge   | 40% after Deductible                             | Not Covered  | Limited to 45 Treatment(s) per Year. Visits combined for physical, occupational, and speech therapy. 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  | 40% after Deductible                                | Not Covered   | Limited to 45 Treatment(s) per Year. Visits combined for physical, occupational, and speech therapy. 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  | 40% 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  | 40% 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  | 40% after Deductible                                | Not Covered   | <a href="#">Cost-sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .  |
| <b>If your child needs dental or eye care</b> | 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>Cosmetic Surgery<br>Long-Term Care<br>Routine Eye Care (Adults)                       | Acupuncture<br>Dental Care (Adults)<br>Non-emergency care when traveling outside the U.S.<br>Routine Foot Care | Bariatric Surgery<br>Infertility Treatment<br>Private-Duty Nursing<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.)                                      |  |  |
| Chiropractic Care   | 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 Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323. 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](http://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](http://www.brighthealthcare.com) or contact the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323.

### 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, kwiiijigo 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> | \$6,700 |
| ▪ <a href="#">Specialist</a> 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 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>       | \$6700        |
| <a href="#">Copayments</a>        | \$1100        |
| <a href="#">Coinsurance</a>       | \$900         |
| What isn't covered                |               |
| Limits or exclusions              | \$60          |
| <b>The total Peg would pay is</b> | <b>\$8760</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> | \$6,700 |
| ▪ <a href="#">Specialist</a> 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 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>       | \$3900        |
| <a href="#">Copayments</a>        | \$300         |
| <a href="#">Coinsurance</a>       | \$0           |
| What isn't covered                |               |
| Limits or exclusions              | \$20          |
| <b>The total Joe would pay is</b> | <b>\$4220</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> | \$6,700 |
| ▪ <a href="#">Specialist</a> 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*)  
 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>       | \$2300        |
| <a href="#">Copayments</a>        | \$300         |
| <a href="#">Coinsurance</a>       | \$0           |
| What isn't covered                |               |
| Limits or exclusions              | \$0           |
| <b>The total Mia would pay is</b> | <b>\$2600</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.