




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 – Individual or \$0 – 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. 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, Inpatient Hospital Services, Inpatient Physician Service, Outpatient - Mental/Behavioral Health Services Office, Inpatient - Mental/Behavioral Health Services, Prenatal and Postnatal Care, Delivery and All Inpatient Services for Maternity Care, Outpatient Rehabilitation Services, Habilitation Services, Skilled Nursing Facility, 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>	Yes. \$4,950 for Prescription Drugs	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket</a></b>	\$8,700 – Individual or	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [https://cdn.bhgplatforms.io/docs/2022\\_COCS/COC\\_83653\\_IFP\\_20220101.pdf](https://cdn.bhgplatforms.io/docs/2022_COCS/COC_83653_IFP_20220101.pdf)  
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<b>limit for this plan?</b>	\$17,400 – Family	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 out-of-pocket limit?</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 network provider?</b>	Yes. See <a href="http://www.brighthousehealthcare.com/search">www.brighthousehealthcare.com/search</a> or call (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.
<b>Do you need a referral to see a specialist?</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge for first 1 visit(s) then \$50	Not Covered	Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay.
	<a href="#">Specialist</a> visit	No charge for first 1 visit(s) then \$100	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab: \$75 X-ray: \$110	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$300	Not Covered	Services require Prior Authorization.
<b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.brighthousehealthcare.com">www.brighthousehealthcare.com</a>	Preferred generic drugs	\$0/\$35	Not Covered	Preventive Care medications are provided at \$0 cost to You, regardless of tier. Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Copays shown reflect the cost per retail prescription.
	Preferred brand drugs and Non-preferred generics	\$200	Not Covered	
	Non-preferred brand drugs and Non-preferred generics	50% after RX Deductible	Not Covered	
	<a href="#">Specialty drugs</a>	50% after RX Deductible	Not Covered	

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$1000	Not Covered	Services require Prior Authorization.
	Physician/surgeon fees	\$300	Not Covered	Services require Prior Authorization.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$1000	\$1000	This cost does not apply if You are admitted directly to the hospital for inpatient services.
	<a href="#">Emergency medical transportation</a>	50%	50%	None
	<a href="#">Urgent care</a>	\$50	\$50	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$3000 per day	Not Covered	Copay applies per day, up to 2 days. Services require Prior Authorization.
	Physician/surgeon fees	\$300	Not Covered	Services require Prior Authorization.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$0	Not Covered	Services require Prior Authorization.
	Inpatient services	\$3000 per day	Not Covered	Copay applies per day, up to 2 days. Services require Prior Authorization.
<b>If you are pregnant</b>	Office visits	\$0	Not Covered	None
	Childbirth/delivery professional services	\$3000	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization. Copay applies per day, up to 2 days.
	Childbirth/delivery facility services	\$3000	Not Covered	
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	50%	Not Covered	Limited to 60 Days per Year. Services require Prior Authorization.
	<a href="#">Rehabilitation services</a>	\$100	Not Covered	Limited to 45 Treatment(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.
	<a href="#">Habilitation services</a>	\$100	Not Covered	Limited to 45 Treatment(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.
	<a href="#">Skilled nursing center</a>	\$3000 per day	Not Covered	Limited to 60 days per calendar year. Copay applies per day, up to 2 days. Services require Prior Authorization.

\* For more information about limitations and exceptions, see the [plan](https://cdn.bhgplatforms.io/docs/2022_COCs/COC_83653_IFP_20220101.pdf) or policy document at [https://cdn.bhgplatforms.io/docs/2022\\_COCs/COC\\_83653\\_IFP\\_20220101.pdf](https://cdn.bhgplatforms.io/docs/2022_COCs/COC_83653_IFP_20220101.pdf)  
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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 the most)	
	<a href="#">Durable medical equipment</a>	50%	Not Covered	Services require Prior Authorization.
	<a href="#">Hospice services</a>	50%	Not Covered	None
<b>If your child needs dental or eye care</b>	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.
	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 <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) Cosmetic Surgery Long-Term Care Routine Eye Care (Adults)	Acupuncture Dental Care (Adults) Non-emergency care when traveling outside the U.S. Routine Foot Care	Bariatric Surgery Infertility Treatment Private-Duty Nursing 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.brighthouse.com](http://www.brighthouse.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, kwijigo 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>	\$0
▪ <a href="#">Specialist</a> copayment	\$100
▪ Hospital (facility) copayment	\$3000
▪ Other co-insurance	50%

#### 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>	\$6700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6760</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>	\$0
▪ <a href="#">Specialist</a> copayment	\$100
▪ Hospital (facility) copayment	\$3000
▪ Other co-insurance	50%

#### 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>	\$3100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4120</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>	\$0
▪ <a href="#">Specialist</a> copayment	\$100
▪ Hospital (facility) copayment	\$3000
▪ Other co-insurance	50%

#### 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>	\$1100
<a href="#">Coinsurance</a>	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1900</b>

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