Coverage Period: 01/01/2022 - 12/31/2022
Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 \$0 – Family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
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, Emergency Transportation/Ambulance, 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, Home Health Care Services, Outpatient Rehabilitation Services, Habilitation Services, Skilled Nursing Facility, Durable Medical Equipment, Hospice Services, Child - Routine Eye	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://cdn.bhgplatforms.io/docs/2022_COCs/COC_87247_IFP_20220101.pdf BHAZ0013-0921 87247AZ0010027-02

	Exam, Child - Eye Glasses, Child - Dental Check-Up	
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$0 – Individual or \$0 – Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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.
Will you pay less if you use a <u>network provider</u> ?	(855) 827 1/1/8 for a list of natwork	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

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

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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	\$0	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.
	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$0 X-ray: \$0	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$0	Not Covered	Services require Prior Authorization.
If you need drugs to treat	Preferred generic drugs	\$0	Not Covered	Preventive Care medications are provided at \$0 cost to

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		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
More information about	Preferred brand drugs and Non- preferred generics	\$0	Not Covered	You, regardless of tier. Covers up to a 90-day supply (retail prescription); 31-	
prescription drug coverage is available at	Non-preferred brand drugs and Non-preferred generics	\$0	Not Covered	90 day supply (mail order prescription). Copays shown reflect the cost per retail prescription.	
www.brighthealthcare.com	Specialty drugs	\$0	Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	Not Covered	Services require Prior Authorization.	
	Physician/surgeon fees	\$0	Not Covered	Services require Prior Authorization.	
If you need immediate medical attention	Emergency room care	\$0	\$0	This cost does not apply if You are admitted directly to the hospital for inpatient services.	
	Emergency medical transportation	\$0	\$0	None	
	<u>Urgent care</u>	\$0	\$0	None	
If you have a hospital	Facility fee (e.g., hospital room)	\$0	Not Covered	Services require Prior Authorization.	
stay	Physician/surgeon fees	\$0	Not Covered	Services require Prior Authorization.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	Not Covered	Cost share shown is for outpatient mental health office visits. Additional costs may apply for other outpatient mental health services. Services require Prior Authorization.	
	Inpatient services	\$0	Not Covered	Services require Prior Authorization.	
	Office visits	\$0	Not Covered	None	
If you are pregnant	Childbirth/delivery professional services	\$0	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery	
	Childbirth/delivery facility services	\$0	Not Covered	or 96 hours for a cesarean delivery require Prior Authorization. None	
If you need help	Home health care	\$0	Not Covered	Limited to 42 Visit(s) per Year. Services require Prior Authorization.	
recovering or have other special needs	Rehabilitation services	\$0	Not Covered	Limited to 60 Visit(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.	

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			What You Will Pay			
Common Medical Event		Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
		Habilitation services	\$0	Not Covered	Limited to 60 Visit(s) per Year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.	
		Skilled nursing center	\$0	Not Covered	Limited to 90 Day(s) per year. Services require Prior Authorization.	
		Durable medical equipment	\$0	Not Covered	Services require Prior Authorization.	
		Hospice services	\$0	Not Covered	None	
		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.	
	If your child needs dental or eye care	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.	

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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.)			
Abortion (except in cases of rape, incest, or when the	Acupuncture	Cosmetic Surgery	
life of the mother is endangered)	Infertility Treatment	Long-Term Care	
Dental Care (Adults)	Routine Eye Care (Adults)	Routine Foot Care	
Non-emergency care when traveling outside the U.S.			
Weight Loss Programs			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Bariatric Surgery	Chiropractic Care	Hearing Aids
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 Arizona Department of Insurance, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007, Phone No. (602) 364-2499 or (800) 325-2548. 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 Us at www.brighthealthcare.com at (855) 827-4448 or the Arizona Department of Insurance, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007, Phone No. (602) 364-2499 or (800) 325-2548.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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.

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About these Coverage Examples



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
 Specialist copayment 	\$0
 Hospital (facility) copayment 	\$0
Other copayment	\$0

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:

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Cost Sharing			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions \$60			
The total Peg would pay is \$60			

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 	\$0
Hospital (facility) copayment	\$0
Other copayment	\$0

This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$20	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
 Hospital (facility) copayment 	\$0
Other copayment	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$0	