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 (844) 926-4524. 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 (844) 926-4524 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $0 – Individual or $0 – Family	See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	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 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?	Yes. $4,950 for Prescription Drugs	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan?	$8,700 – Individual or $17,400 – 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, 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 network provider?	Yes. See www.brighthealthcare.com/search or call (844) 926-4524 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?	No	You can see the specialist you choose without a referral.

⚠ 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)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No charge for first 1 visit(s) then $50	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral. Telehealth services are available. Refer to Your Schedule of Benefits to determine what You will pay.
	Specialist visit	No charge	No charge for first 1 visit(s) then $100	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services are needed are preventive. Then check what your plan will pay for and what Your cost will be.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Lab: $75 X-ray: $110	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.

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)	
	Imaging (CT/PET scans, MRIs)	No charge	$300	Not Covered	Services require Prior Authorization.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.brighthealthcare.com	Generic drugs	No charge	$0/$35	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. Cost-sharing waived at non-IHCP with IHCP referral.
	Preferred brand drugs	No charge	$200	Not Covered	
	Non-preferred brand drugs	No charge	50% after RX Deductible	Not Covered	
	Specialty drugs	No charge	50% after RX Deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$1000	Not Covered	Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	$300	Not Covered	Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
If you need immediate medical attention	Emergency room care	No charge	$1000	$1000	This cost does not apply if You are admitted directly to the hospital for inpatient services. Cost-sharing waived at non-IHCP with IHCP referral.
	Emergency medical transportation	No charge	50%	50%	Cost-sharing waived at non-IHCP with IHCP referral.
	Urgent care	No charge	$50	$50	Cost-sharing waived at non-IHCP with IHCP referral.

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$3000 per day	Not Covered	Copay applies per day, up to 2 days. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	$300	Not Covered	Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$0	Not Covered	Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	$3000 per day	Not Covered	Copay applies per day, up to 2 days. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	$0	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery professional services	No charge	$3000	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral. 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	No charge	$3000	Not Covered	
If you need help recovering or have other special needs	Home health care	No charge	50%	Not Covered	Limited to 60 Visit(s) per Year. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.

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)	
	Rehabilitation services	No charge	$100	Not Covered	Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Habilitation services	No charge	$100	Not Covered	Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Skilled nursing center	No charge	$3000 per day	Not Covered	Limited to 25 Visit(s) per Year. Copay applies per day, up to 2 days. Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.

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)	
	Durable medical equipment	No charge	50%	Not Covered	Services require Prior Authorization. Cost-sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	50%	Not Covered	Cost-sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	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. Cost-sharing waived at non-IHCP with IHCP referral.
	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. Cost-sharing waived at non-IHCP with IHCP referral.
	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. Cost-sharing waived at non-IHCP with IHCP referral.

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 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 plan 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. The contact information for those agencies is: Texas Department of Insurance (TDI) at 1-800-252-3439. 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 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: Texas Department of Insurance at 1-800-578-4677 or visit www.tdi.texas.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? 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 (844) 926-4524.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 926-4524.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (844) 926-4524.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (844) 926-4524.

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 plan's overall deductible $0
- Specialist 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 tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$6700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6760**

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 $100
- Hospital (facility) copayment $3000
- Other co-insurance 50%

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3100
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $0
- Specialist 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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1900**

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.