



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: Individual \$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. Primary Care Visit to Treat an Injury or Illness, Specialist Visit, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, Outpatient Facility Fee, Outpatient Surgery Physician/Surgical Services, Emergency Room Services, Urgent Care Centers or Facilities, Inpatient Physician Service, Outpatient - Mental/Behavioral Health Services Office, Prenatal and Postnatal Care, 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$7,000: Individual \$14,000: 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	Yes. See	This plan uses a provider network . You will pay less if you use a provider in the plan's network .

* For more information about limitations and exceptions, see the [plan](#) or policy document at

https://cdn1.brighthealthplan.com/docs/2023_COCs/COC_98312_ADV_20230101.pdf
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a network provider ?	www.brighthousehealthcare.com/search or call (844) 926-4524 for a list of network providers .	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
		Network Provider (You will pay the least)	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	\$0	Not Covered	24/7 Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay.
	Specialist visit	\$40	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 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)	Lab: \$30 X-ray: 25%	Not Covered	None
	Imaging (CT/PET scans, MRIs)	25%	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 https://brighthousehealthcare.com/individual-and-family/drug-search .	Preferred generic drugs	\$0/\$10	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. Mail order copays are 2.5 times the retail cost. No charge applies for certain generic drugs. View the formulary for Tier 6 generic drugs.
	Preferred brand drugs and Non-preferred generics	\$50	Not Covered	
	Non-preferred brand drugs and Non-preferred generics	\$125	Not Covered	
	Specialty drugs	30%	Not Covered	

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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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300	Not Covered	Services require Prior Authorization. Other charges may apply for additional services rendered, e.g. lab, x-ray.
	Physician/surgeon fees	\$100	Not Covered	Services may require Prior Authorization.
If you need immediate medical attention	Emergency room care	\$500	\$500	This cost does not apply if You are admitted directly to the hospital for inpatient services. Other charges may apply for additional services rendered, e.g. lab, x-ray.
	Emergency medical transportation	25%	25%	Emergency transportation services must be Medically Necessary .
	Urgent care	\$50	\$50	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25%	Not Covered	Services may require Prior Authorization. Other charges may apply for additional services rendered, e.g. lab, x-ray.
	Physician/surgeon fees	\$100	Not Covered	Services may require Prior Authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$0 Other 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 may require Prior Authorization.
	Inpatient services	25%	Not Covered	Services require Prior Authorization.
If you are pregnant	Office visits	\$0	Not Covered	None
	Childbirth/delivery professional services	25%	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization.
	Childbirth/delivery facility services	25%	Not Covered	
If you need help recovering or have other special needs	Home health care	25%	Not Covered	Services may require Prior Authorization. Limited to 60 Visit(s) per Year.

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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)	
	Rehabilitation services	25%	Not Covered	Services may require Prior Authorization. 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.
	Habilitation services	25%	Not Covered	Services may require Prior Authorization. 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.
	Skilled nursing care	25%	Not Covered	Services require Prior Authorization. Limited to 25 Visit(s) per Year.
	Durable medical equipment	25%	Not Covered	Services may require Prior Authorization.
	Hospice services	25%	Not Covered	None
If your child needs dental or eye care	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.

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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)	
	Children's dental checkup	\$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](#).)

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|--|-------------------------|---------------------|
| • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | • Acupuncture | • Bariatric Surgery |
| • Cosmetic Surgery | • Infertility Treatment | • Long-Term Care |
| • Non-emergency care when traveling outside the U.S. | • Private-Duty Nursing | • Routine Foot Care |
| • 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 | • Dental Care (Adults) | • Hearing Aids |
| • Routine Eye Care (Adults) | | |

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? 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 (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, kwijigo holne' (844) 926-4524.

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 [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	\$40
▪ Hospital (facility) co-insurance	25%
▪ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$2500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3060

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	\$40
▪ Hospital (facility) co-insurance	25%
▪ Other copayment	\$0

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1000
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1220

Mia's Simple Fracture

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

▪ The plan's overall deductible	\$0
▪ Specialist copayment	\$40
▪ Hospital (facility) co-insurance	25%
▪ Other copayment	\$0

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1000

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