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
What is the overall deductible?	$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. Primary Care, Specialty Care, Lab and X-ray services, some Prescription Drugs, Urgent Care, Outpatient Mental Health, Inpatient and Outpatient Hospital care, and Pediatric Dental and Vision are covered before the deductible.	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, Prescription Drugs. $4,950 Individual or $9,900 Family	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?	$8,550 Individual or $17,100 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 https://brighthealthplan.com/provider-finder/ifp or call 1-855-827-4448 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_44522_20210101.pdf.

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	$50	Not covered	None
	Specialist visit	$100	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.
If you have a test	Diagnostic test (x-ray, blood work)	Labs $50 per visit X-ray $100 per visit	Not covered	Pre-authorization is required for Imaging (CT/PET/MRI).
	Imaging (CT/PET scans, MRIs)	$300	Not covered	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.brighthealthplan.com	Generic drugs (Tier 2)	$30	Not covered	Tier 1 drugs are Preventive medications that are of $0 cost to you. Copays shown reflect the cost per retail prescription for a 30-day supply. Mail Order copays are 2.5 times the Retail cost for a 90-day supply.
	Preferred brand drugs (Tier 3)	$200	Not covered	
	Non-preferred brand drugs (Tier 4)	50%	Not covered	
	Specialty drugs (Tier5)	50%	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000	Not covered	Services require pre-authorization.
	Physician/surgeon fees	$300	Not covered	
If you need immediate medical attention	Emergency room care	$1,000	$1,000	None
	Emergency medical transportation	50%	50%	
	Urgent care	$50	$50	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,500 per day	Not covered	Copay applies to first 2 days of hospitalization. Services require pre-authorization.

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_44522_20210101.pdf.

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)	
	Physician/surgeon fees	$300	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50	Not covered	None
	Inpatient services	$2,500 per day	Not covered	Copay applies to first 2 days of hospitalization. Services require pre-authorization.
If you are pregnant	Office visits	No charge	Not covered	Copay applies to first 2 days of hospitalization. Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$2,500 per day	Not covered	
If you need help recovering or have other special needs	Home health care	50%	Not covered	Services require pre-authorization.
	Rehabilitation services	$100	Not covered	Services require pre-authorization.
	Habilitation services	$100	Not covered	Services require pre-authorization.
	Skilled nursing center	$2,500 per day	Not covered	Copay applies per day up to 2 days. Services require pre-authorization.
	Durable medical equipment	50%	Not covered	Services require pre-authorization.
	Hospice services	50%	Not covered	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 eye exam per calendar year through the end of the month in which the dependent child turns 19.

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_44522_20210101.pdf.

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 glasses	No charge	Not covered	Limited to 1 pair of glasses including standard frames and standard lenses, or a one-year supply of contact lenses through the end of the month in which the dependent child turns 19.
	Children's dental checkup	No charge	Not covered	Includes diagnostic and preventive services for dependent children 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
Acupuncture Cosmetic Surgery Dental Care (Adults)	Long Term Care Non-emergency care when traveling outside the U.S.	Routine eye care (Adults) Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Abortion Bariatric Surgery Chiropractic Care	Hearing Aids Infertility Treatment Private-duty nursing	Routine foot care (for diabetes)

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_44522_20210101.pdf.

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 Illinois Department of Insurance at 1-877-527-9431. 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: Bright Health at www.brighthealthplan.com or contact the Illinois Department of Insurance at 1-877-527-9431.

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, kwiijigo holne' (855) 827-4448.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_44522_20210101.pdf.

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 copay $100
- Hospital (facility) copay $2,500 per day
- Other coinsurance 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	$6000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6600**

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 copay $100
- Hospital (facility) copay $2,500 per day
- Other coinsurance 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	$0
Copayments	$5400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5420**

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

- The plan's overall deductible $0
- Specialist copay $100
- Hospital (facility) copay $1,000
- Other coinsurance 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**

The plan would be responsible for the other costs of these EXAMPLE covered services.