
 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 1-855-435-0435. For general 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://member.brighthealthplan.com/> or call 1-855-435-0435 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,200 Individual or \$6,400 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the deductible amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care, Specialty Care, Urgent Care, Prescription Drugs, and Pediatric Dental and Vision care are covered before the deductible.	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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,900 Individual or \$15,800 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://member.brighthealthplan.com/providers">https://member.brighthealthplan.com/providers</a> or call 1-855-435-0435 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 plan's <a href="#">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 provider's 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$75 copay/visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	\$0 copay/visit	Not Covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Services require pre-authorization.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://member.brighthealthhplan.com/">https://member.brighthealthhplan.com/</a>	Generic drugs	\$15/prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$80/prescription	Not Covered	
	Non-preferred brand drugs	\$180/prescription	Not Covered	Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost.
	<a href="#">Specialty drugs</a>	\$650/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	Not Covered	Services require pre-authorization.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% coinsurance	20% coinsurance	None
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None
	<a href="#">Urgent care</a>	\$55 copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	20% coinsurance	Not Covered	Services require pre-authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 copay/visit	Not Covered	None
	Inpatient services	20% coinsurance	Not Covered	Services require pre-authorization.

\* For more information about limitations and exceptions, see the plan or policy document at <https://member.brighthealthplan.com/>.

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 are pregnant	Office visits	20% coinsurance	Not Covered	None
	Childbirth/delivery professional services	20% coinsurance	Not Covered	Delivery stays exceeding 48 hours for vaginal deliver or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery facility services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	Not Covered	Limited to 28 hours per week. Services require pre-authorization.
	<a href="#">Rehabilitation services</a>	20% coinsurance	Not Covered	Limited to 30 visits combined between speech, occupational, and physical therapy. Visit limit does not apply to therapies for the treatment of autism. Services require pre-authorization.
	<a href="#">Habilitation services</a>	20% coinsurance	Not Covered	Limited to 30 visits combined between speech, occupational, and physical therapy. Visit limit does not apply to therapies for the treatment of autism. Services require pre-authorization.
	<a href="#">Skilled nursing care</a>	20% coinsurance	Not Covered	Limited to 100 days per year. Services require pre-authorization.
	<a href="#">Durable medical equipment</a>	20% coinsurance	Not Covered	Services require pre-authorization.
	<a href="#">Hospice services</a>	20% coinsurance	Not Covered	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	\$0 copay/visit	Not Covered	Limited to 1 exam per year for members up to the end of the month in which they turn 19.
	Children's glasses	No charge up to the provider's contracted amount.	Not Covered	Limited to 1 pair of glasses, including frames and lenses or contact lenses, every year for members up to the end of the month in which they turn 19.
	Children's dental check-up	\$0 copay/visit	\$0 copay/visit	Includes diagnostic and preventive services for members up to the end of the month in which the member turns 19. Refer to the Certificate of Coverage for covered services and limitations.

\* For more information about limitations and exceptions, see the plan or policy document at <https://member.brighthealthplan.com/>.

## 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) | • Hearing Aids                                       | • Private-duty Nursing      |
| • Acupuncture  | • Infertility Treatment                              | • Routine eye care (Adults) |
| • Bariatric Surgery  | • Long Term Care                                     | • Routine foot care         |
| • Cosmetic Surgery   | • Non-emergency care when traveling outside the U.S. | • Weight loss programs      |
| • Dental Care (Adults)   |  |                             |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department at 334-241-4141 or via FAX 334-956-7932 or e-mail at [ConsumerServices@insurance.alabama.gov](mailto:ConsumerServices@insurance.alabama.gov). Other coverage options may be available to you too, including buying individual insurance coverage through [Healthcare.gov](http://Healthcare.gov). For more information about [Healthcare.gov](http://Healthcare.gov), visit [www.healthcare.gov](http://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 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](http://www.brighthealthplan.com) or 1-855-435-0435.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-855-435-0435.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-435-0435.

Chinese (中文): 如果需要中文的帮助, ☐☐打☐个号☐ 1-855-435-0435.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-435-0435.

-----*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](#) \$3,200
- [Specialist](#) copayment \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$120
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,860</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist](#) copayment \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,710
Copayments	\$1,750
Coinsurance	\$430
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,950</b>

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

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist](#) copayment \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,090
Copayments	\$230
Coinsurance	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,590</b>



## Language Assistance Services

If You or someone you're helping has questions about Bright Health, You have the right to get help and information in Your language, at no cost. To talk to an interpreter, call (855) 453-0435.

### *Spanish*

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Bright Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (855) 453-0435.

### *Chinese*

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Bright Health方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (855) 453-0435。

### *Korean*

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Bright Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (855) 453-0435로 전화하십시오.

### *Vietnamese*

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Bright Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (855) 453-0435.

### *Arabic*

فلديك الحق في الحصول على المساعدة والمعلومات، Bright Health، إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص  
(855) 453-0435 الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب

### *German*

Falls Sie oder jemand, dem Sie helfen, Fragen zum Bright Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (855) 453-0435 an.

### *French*

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Bright Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (855) 453-0435.

### *Gujarati*

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં છો તેમ જ કોઇને Bright Health વિશે પ્રશ્નો હોય તો તમને મદદ અને મહત્તી મેળિનો અવિકર છે. તે ખર્ચ વિન તમ રી ભષ મોં પ્ર મ કરી શક ર છે. દ ભ વષરો િ ત કરિ મ ટે,આ (855) 453-0435 પર કોલ કરો.



#### *Tagalog*

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Bright Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (855) 453-0435.

#### *Hindi*

यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Bright Health के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषण से बात करने के लिए (855) 453-0435 पर कॉि करें।

#### *Laotian*

ຖ້າທ່ານ, ຫຼື ຄົນທີ່ ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ Bright Health, ທ່ານມີ ສິດທີ່ ອໍ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ອໍ່ອີ່ແລະຂໍ້ມູນຂ່າວສານທີ່ ອໍ່ເປັນພາສາຂອງທ່ານບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັບກັບນາຍພາສາ, ໃຫ້ໂທຫາ (855) 453-0435.

#### *Russian*

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Bright Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (855) 453-0435.

#### *Portuguese*

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Bright Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (855) 453-0435.

#### *Turkish*

Sizin veya yardım ettiğiniz birinin Bright Health hakkında sorularınız varsa, kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman ile konuşmak için (855) 453-0435 numaralı hattı arayın.

#### *Japanese*

ご本人様、またはお客様の身の回りの方でも、Bright Healthについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(855) 453-0435までお電話ください。