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 1-866-217-8016. 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 1-866-217-8016 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,500 Individual or $11,000 Family	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, Outpatient Mental Health, Urgent Care, and Generic and Preferred Brand Prescription Drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,900 Individual or $15,800 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://member.brighthealthplan.com/ or call 1-866-217-8016 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.

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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	$40 copay/visit	Not Covered	None
	Specialist visit	$75 copay/visit	Not Covered	None
	Preventive care/screening/ immunization	No charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	Services require pre-authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://member.brighthealthplan.com/.	Generic drugs	$25 copay/prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost. Some specialty medications are available in other tiers. Review our formulary at https://member.brighthealthplan.com to determine what tier your specialty medication falls in.
	Preferred brand drugs	$100 copay/prescription	Not Covered	
	Non-preferred brand drugs	40% coinsurance	Not Covered	
	Specialty drugs	40% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	40% coinsurance	Not Covered	Services require pre-authorization.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$75 copay/visit	Not Covered	Copay applies to facility charges. Ancillary charges such as lab or x-ray services will apply the plan's deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	40% coinsurance	Not Covered	Services require pre-authorization.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$75 copay/visit	Not Covered	None
	Inpatient services	40% coinsurance	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	40% coinsurance	Not Covered	None
	Childbirth/delivery professional services	40% 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	40% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Limited to 42 visits per calendar year. Services require pre-authorization.
	Rehabilitation services	40% coinsurance	Not Covered	Limited to 60 visits combined per calendar year between speech, occupational, and physical therapy. Services require pre-authorization. Visit limit does not apply to therapies for the treatment of autism.
	Habilitation services	40% coinsurance	Not Covered	
	Skilled nursing care	40% coinsurance	Not Covered	Limited to 90 days per calendar year. Services require pre-authorization.
	Durable medical equipment	40% coinsurance	Not Covered	Services require pre-authorization.
	Hospice services	40% coinsurance	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 exam per year.
	Children's glasses	Covered in full up to the provider's contracted amount.	Not Covered	Limited to 1 pair of glasses per calendar year, including frames and lenses; or a one-year supply of contact lenses per calendar year.
	Children's dental check-up	No charge	No charge	Refer to the Schedule of Benefits 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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment (diagnosis only)
- Private-duty nursing (when Medically Necessary)
- Routine foot care (when provided in connection to treatment of diabetes only)

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: 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 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 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: 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

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 1-866-217-8016.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-217-8016.
Chinese (中文): 如果需要中文的帮助，□□打□个号□ 1-866-217-8016.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-217-8016.

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://member.brighthealthplan.com/.

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	$5,500
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,940
Copayments	$0
Coinsurance	$4,960
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,960

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

The plan's overall deductible	$5,500
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,120
Copayments	$2,550
Coinsurance	$740
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$4,470

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

The plan's overall deductible	$5,500
Specialist *copayment*	$75
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$980
Copayments	$230
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,860

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

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 1-866-217-8016.

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 1-866-217-8016.

Navajo
Dii kwe'é atah nílínígíí Bright Health haada yit' éego bína'ídíłkidgo éí doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz' a doo baah ílínígóó. Ata' halne'ígíí koji' bich'i' hodíílnih 1-866-217-8016.

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 1-866-217-8016。

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 1-866-217-8016.

Arabic
فلديك الحق في الحصول على المساعدة، Bright Health إن كان لديك أو لدى شخص تساعده أسئلة بخصوص والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-866-217-8016.

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 1-866-217-8016.

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 1-866-217-8016로 전화하십시오.

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 1-866-217-8016.

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 1-866-217-8016 an.

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 1-866-217-8016.

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、1-866-217-8016までお電話ください。

Persian
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Bright Health ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید . تماس حاصل نمایید 8016-217-866-1.

Syriac
ܫܘܐܠ ܒܗ ܐܘ ܥܡ ܕܐܢܬ ܥܒܕ ܠܗ ܛܝܒܘܬܐ، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܗܘܐ ܥܡ Bright Health، ܘܐܦ ܠܟ ܙܟܘܬܐ ܕܬܩܒܠ ܥܕܪܐ ܘܝܕܥܢܐ ܒܠܫܢܟ. ܕܐܢ ܒܥܝܢ ܐܢܬ ܕܬܡܠܠ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܘ ܠܡܣܦܪܐ 8016-217-866-1

Serbo-Croatian
Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Bright Health, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-866-217-8016.

Thai
ประกาศนียบัตรสูงสาคญั ประกาศนียบัตรมัธยมสาคญเกี่ยวกบการการสมครหรือขอบเขตประกนสขภาพของคณุ ผ่าน Bright Health ดงู าหนดการในประกาศนี้ คณุ อาจจะต้องดาเนินการภายในก าหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกนสขภาพของคณุ หรือการช่วยเหลือที่มีค่าใช้จ่าย คณมีสิทธิที่จะได้รับข้อมลและความช่วยเหลือนี้ในภาษาของคณโดยไม่มีค่าใช้จ่าย โทร 1-866-217-8016.