




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 1-866-238-7195. 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 1-866-238-7195 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$6,750 Individual or \$13,500 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. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
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> ?	\$6,750 Individual or \$13,500 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.
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/">https://member.brighthealthplan.com/</a> or call 1-866-238-7195 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	\$0 after deductible	Not Covered	None
	<a href="#">Specialist</a> visit	\$0 after deductible	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$0 after deductible	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.brighthealthplan.com/">https://member.brighthealthplan.com/</a> .	Generic drugs	\$0 after deductible	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 <a href="https://member.brighthealthplan.com">https://member.brighthealthplan.com</a> to determine what tier your specialty medication falls in.
	Preferred brand drugs	\$0 after deductible	Not Covered	
	Non-preferred brand drugs	\$0 after deductible	Not Covered	
	<a href="#">Specialty drugs</a>	\$0 after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 after deductible	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	\$0 after deductible	Not Covered	Services require pre-authorization.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$0 after deductible	\$0 after deductible	None
	<a href="#">Emergency medical transportation</a>	\$0 after deductible	\$0 after deductible	None
	<a href="#">Urgent care</a>	\$0 after deductible	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)	\$0 after deductible	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	\$0 after deductible	Not Covered	Services require pre-authorization.

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

 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	\$0 after deductible	Not Covered	None
	Inpatient services	\$0 after deductible	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	\$0 after deductible	Not Covered	None
	Childbirth/delivery professional services	\$0 after deductible	Not Covered	Delivery stays exceeding 48 hours for vaginal deliver or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery facility services	\$0 after deductible	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0 after deductible	Not Covered	Limited to 60 visits per calendar year. Services require pre-authorization.
	<a href="#">Rehabilitation services</a>	\$0 after deductible	Not Covered	Limited to 20 Habilitative Outpatient Therapy visits per type per calendar year and 20 Rehabilitative Outpatient Therapy visits per type per calendar year.
	<a href="#">Habilitation services</a>	\$0 after deductible	Not Covered	Visit limit is combined for all diagnoses, including autism.  Services require pre-authorization.
	<a href="#">Skilled nursing care</a>	\$0 after deductible	Not Covered	Limited to 60 days per calendar year. Services require pre-authorization.
	<a href="#">Durable medical equipment</a>	\$0 after deductible	Not Covered	Services require pre-authorization.
	<a href="#">Hospice services</a>	\$0 after deductible	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	\$0 after deductible	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) | • Cosmetic Surgery                                   | • Private-duty nursing      |
| • Acupuncture  | • Dental Care (Adults)                               | • Routine eye care (Adults) |
| • Bariatric Surgery  | • Long Term Care                                     | • Weight loss programs      |
|  | • Non-emergency care when traveling outside the U.S. |                             |

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

- |  |  |   |
|--|--|---|
| • Chiropractic Care                              | • Infertility Treatment (diagnosis only) | • Routine foot care (when provided in connection to treatment of diabetes only) |
| • Hearing Aids (limited to members under age 18) |  |   |

**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: Tennessee Department of Commerce and Insurance at 1-800-342-4029. 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: Tennessee Department of Commerce and Insurance at 1-800-342-4029.

**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 1-866-238-7195.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-238-7195.

Chinese (中文): 如果需要中文的帮助, ☐☐打☐个号☐ 1-866-238-7195.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-238-7195.

-----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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,750
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,750
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,810

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,750
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$6,750
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$6,810

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,750
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

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 866-283-9427.

### *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 866-283-9427.

### *Arabic*

فأدرك الحق في الحصول على المساعدة، Bright Health، إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص المعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 9427-283-866.

### *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 866-283-9427]。

### *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 866-283-9427.

### *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 866-283-9427로 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 866-283-9427.

### *Laotian*

ຖ້າ ກ່າວ ການ, ຫຼື ສົ ນ ທ່າ ການ ກ່າວ ງ່າ ວຍເຫຼື ອ, ມ ອໍຣາຖາມກ່ ງວກ ບ Bright Health, ທ່ ການ ອໍສດ ທຈະໄດ້ ສ່ ບການຊ່ ວຍເຫຼື ອແລະ ຂໍ້ ນູ ນຊ່ າວສານ ທເບີ ນພາສາຂອງທ່ ານ ບໍ່ມ ສ່ າໃຊ້ ຈ່ ສການໃຫ້ ລໍ ມກ້ ບນາຍພາສາ, ໃຫ້ ໂທຫາ 866-283-9427.

### *Amharic*

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Bright Health ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 866-283-9427 ይደውሉ።



### 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 866-283-9427 an.

### Gujarati

જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં છો તેમ થાં તો કોઈને [એસબીએમ કાર્યક્રમનાં નમૂનાઓ] વિશે પ્રશ્નો હોય તો તમને મદદ અને મહત્તી મેળિં નો અવિકર છે. તે ખર્ચ વિન તમ રી ભષમનાં પ્રત કરી શક ર છે. દ ભવર્ષો િત કરિ મટે, આ [અહીં દ ખલ કરો નબર] પર કોલ કરો.

### 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、866-283-9427までお電話ください。

### Tagalog

Kung ikaw, o ang iyong tinutulungan, 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 866-283-9427.

### Hindi

यदि आपके ,या आप द्वारा सहायता कए जा रहे ककसी व्यक्त 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 विभिन्न भाषा से बात करने के लिए ,866-283-9427 पर कॉल करें।

### 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 866-283-9427.

### Persian

داشته باشید حق این را دارید که کمک ، Bright Health اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد . و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 9427-283-866 . تماس حاصل نمایید