



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 1-855-453-0435. 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 1-855-453-0435 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,500 Individual or \$7,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Primary Care, Specialty Care, Prescription Drugs, Urgent Care, Outpatient Mental Health, 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$8,150 Individual or \$16,300 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
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/providers or call 1-855-453-0435 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 .



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 for the first visit, then \$30 per visit	Not Covered	Free visit includes the office visit only.
	Specialist visit	\$80 copay/visit	Not Covered	None
	Preventive care/screening/immunization	\$0 copay/visit	Not Covered	None
If you have a test	Diagnostic test (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 prescription drug coverage is available at https://member.brighthealthplan.com	Generic drugs	\$15 copay/prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$100 copay/prescription	Not Covered	
	Non-preferred brand drugs	\$200 copay/prescription	Not Covered	
	Specialty drugs	\$680 copay/prescription	Not Covered	Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost.
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	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$75 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	\$80 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 delivery 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	Home health care	20% coinsurance	Not Covered	Services require pre-authorization.
	Rehabilitation services	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.
	Habilitation services	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.
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 100 days per year. Services require pre-authorization.
	Durable medical equipment	20% coinsurance	Not Covered	Services require pre-authorization.
	Hospice services	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 standard frames and standard 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.

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) | • 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 email at ConsumerServices@insurance.alabama.gov. Other coverage options may be available to you too, including buying individual insurance coverage through Healthcare.gov. For more information about Healthcare.gov, 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 Bright Health at www.brighthealthplan.com or 1-855-453-0435.

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 1-855-453-0435.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-453-0435.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-453-0435.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-453-0435.

—————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	\$3,500
■ Specialist copayment	\$80
■ 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$120
Coinsurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,160

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,500
■ Specialist copayment	\$80
■ 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,490
Copayments	\$2,170
Coinsurance	\$370
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,090

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,500
■ Specialist copayment	\$80
■ 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*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,310
Copayments	\$240
Coinsurance	\$330
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,880

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

Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:

Assistance is available *at no cost* to help you communicate with us. Services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call the Member Services number on your member ID card.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
Bright Health
P.O. Box 16275
Reading, PA 19612-6275
Phone: (844) 202-2154
Email: OAG@brighthealthplan.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- **Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)
- **Mail:** U.S Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

If you need help with your complaint, please call the Member Services number on your member ID card. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

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English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the Member Services number on your ID card.
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. اتصل برقم خدمات الأعضاء الموجود على بطاقة تعريف الهوية الخاصة بك.
Chinese (S)	注意: 如果您使用的语言并非英语, 则可获得免费的语言协助服务。请拨打身份证上的会员服务号码。
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique sont mis gratuitement à votre disposition. Appelez le numéro des services aux membres figurant sur votre carte d'identification.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die Mitgliederservice-Nummer auf Ihrer ID-Karte.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card).
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero Member Services che trova sulla Sua tessera identificativa.
Japanese	ご注意: 英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただけます。IDカードに記載されているメンバーサービスの番号までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 신분증에 기재된 회원 서비스 번호로 연락하십시오.
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług tłumaczeniowych. Zadzwoń na numer obsługi podany na twojej karcie identyfikacyjnej.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma para si. Contacte o número de serviços para membros no seu cartão de identificação.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Отдел обслуживания участников программы по телефону, указанному на вашей идентификационной карточке.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Comuníquese al número de Servicios para miembros que figura en su tarjeta de ID.
Tagalog	PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga serbisyong tulong sa wika nang walang bayad. Tumawag sa numero ng Member Services na nasa iyong ID card.

ناگاداری: نه‌گهر به زمانیکه تری جگه له نینگیزی فسه ده‌کیت، خزمه‌نگوزاره زمانه‌وانیه‌کان به‌خو‌رای بی تو به‌ده‌ستن. یه‌ه‌ندی به ژماره‌ی خزمه‌نگوزاره‌ی نه‌ندامانه‌ سه‌ه‌ ناسنامه‌کیت بکه‌.

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