



**Schedule of Benefits**  
**Bronze \$0 Medical Deductible**  
**(Who Pays What)**  
**From 01/01/2022 through 12/31/2022**

This Schedule of Benefits does not explain all benefits in detail. For a complete explanation of Your benefits, you should read Your entire Policy.

**THIS PLAN UTILIZES A PROVIDER NETWORK**

This plan uses a Provider Network to provide Covered Health Services to You, which means You will have less out-of-pocket expenses if You receive care from In-Network or Participating Providers.

You can review our provider network online at [www.brighthealthcare.com](http://www.brighthealthcare.com), or You can contact Bright HealthCare Customer Service at (844) 926-4524 to locate a provider or request a paper copy of the provider directory.

**Deductible**

A Deductible is the amount that a Covered Person must pay before Bright HealthCare pays any benefits for Covered Health Services. The Deductible amount does not include Percentage Copayment, Copayment, or non-covered charges.

**Copayment**

Copayments are the charges stated as a set dollar amount that You are required to pay for certain Covered Health Services. Copayment amounts accumulate towards Your Out-of-Pocket Maximum. Copayment charges for the calendar year will not exceed 200 percent of the total annual premium cost.

**Percentage Copayment**

Percentage Copayment is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services. Percentage Copayment amounts accumulate towards Your Out-of-Pocket Maximum. Percentage Copayment charges will not exceed 50 percent of the total cost of services provided.

**Out-of-Pocket Maximum**

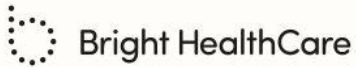
The Out-of-Pocket Maximum is the maximum amount of Deductible, Percentage Copayment, or Copayments You pay in a calendar year. All Deductible, Copayment and Percentage Copayment payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Percentage Copayment amounts for Covered Health Services received from a participating Bright HealthCare Provider for the remainder of the Calendar Year.

For policies with two or more people, each Covered Person's Individual Out-of-Pocket Maximum applies to the Family Out-of-Pocket Maximum. Once a Covered Person has met his or her Out-of-Pocket Maximum, the Covered Person will have no further obligation to pay charges for In-Network Covered Health Services for the remainder of the Calendar Year. Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Out-of-Pocket Maximum, Covered Persons under the Family policy will have no further obligation to pay charges for In-Network Covered Health Services.

**Limitations/Exclusions**

Some limitations are listed in this Schedule of Benefits. Refer to Your policy for a more comprehensive listing and description of services or items that are limited or excluded from covered by the Plan.

<b>General Cost Share &amp; Features</b>	<b>In Network</b>	<b>Non Network</b>
<b>Deductible:</b> Per Plan Year - Medical only  - Rx only	\$0/Individual; \$0/Family  \$4,950/Individual; \$9,900/Family	Not Covered
<b>Out-of-Pocket Maximum:</b> - Per Plan Year	\$8,700/Individual; \$17,400/Family	Not Covered



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Benefit	In Network	Non Network
<b>Allergy Services</b>		
Physician Services	\$100 per Visit	Not Covered
Allergy Testing	50%	Not Covered
Allergy Serum	50%	Not Covered

Benefit	In Network	Non Network
<b>Autism Spectrum Disorder Services</b>		
Outpatient Therapy Services <i>Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Autism - Applied Behavioral Analysis <i>Services require Prior Authorization.</i>	\$300 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Chemotherapy &amp; Radiation Treatment</b>		
Chemotherapy Treatment <i>Services require Prior Authorization.</i>	50%	Not Covered
Radiation Treatment <i>Services require Prior Authorization.</i>	50%	Not Covered

Benefit	In Network	Non Network
<b>Chiropractic Care</b>		
Spinal Manipulations <i>Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Diagnostic X-ray Services	\$110 per Encounter	Not Covered

Benefit	In Network	Non Network
<b>Dialysis Services</b>		
Dialysis Treatment <i>Services require Prior Authorization.</i>	50%	Not Covered



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Benefit	In Network	Non Network
<b>Durable Medical Equipment</b>		
Durable Medical Equipment and Devices <i>Services require Prior Authorization.</i>	50%	Not Covered
Diabetic Shoes <i>Services require Prior Authorization.</i>	50%	Not Covered
Ostomy Supplies <i>Services require Prior Authorization.</i>	50%	Not Covered
Equipment for the treatment of Positional Plagiocephaly <i>Services require Prior Authorization.</i>	50%	Not Covered

Benefit	In Network	Non Network
<b>Emergency Health Services</b>		
<i>Non-emergent services received in an emergency room are generally not covered. See Your Policy for the definition of Emergency Health Services and/or Emergency Care.</i>		
Emergency Room Facility	\$1000 per Admission	\$1000 per Admission
Emergency Room Physician/ Surgeon charges	\$300 per Admission	\$300 per Admission
Professional Fees	\$300 per Admission	\$300 per Admission
Anesthesia	\$300 per Encounter	\$300 per Encounter
Laboratory Services	\$75 per Admission	\$75 per Admission
Radiology Services	\$110 per Admission	\$110 per Admission
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$300 per Encounter	\$300 per Encounter
Emergency Room Ancillary Charges	\$300 per Encounter	\$300 per Encounter
Emergency Ambulance Transport (Ground/Air/Water)	50%	50%

Benefit	In Network	Non Network
<b>Genetic Testing and Counseling</b>		
Genetic Testing and Counseling <i>Services require Prior Authorization.</i>	50%	Not Covered

Benefit	In Network	Non Network
<b>Hearing Services</b>		
Hearing Screening <i>Limited to 1 preventive care hearing screening per calendar year to determine the need for hearing correction.</i>	\$0 per Visit	Not Covered



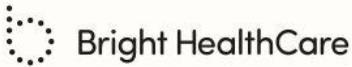
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Benefit	In Network	Non Network
Hearing Exam/Evaluation	\$100 per Visit	Not Covered
Hearing Aids	50%	Not Covered

Benefit	In Network	Non Network
<b>Home Health Care</b>		
Home Health <i>Limited to 60 Visit(s) per Year. Services require Prior Authorization.</i>	50%	Not Covered
Home Infusion Therapy	50%	Not Covered

Benefit	In Network	Non Network
<b>Hospice Care Services</b>		
Hospice Care	50%	Not Covered
Bereavement Support Services	\$0 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Hospital Services &amp; Inpatient Surgery, including Organ &amp; Tissue Transplants</b> <i>All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.</i>		
Inpatient Hospital Facility/Surgery <i>Copay applies per day, up to 2 days. Services require Prior Authorization.</i>	\$3000 per Visit	Not Covered
Inpatient Habilitation/ Rehabilitation Facility <i>Services require Prior Authorization.</i>	\$100 per Admission	Not Covered
Skilled Nursing Facility <i>Limited to 25 Visit(s) per Year. Copay applies per day, up to 2 days. Services require Prior Authorization.</i>	\$3000 per Visit	Not Covered
Professional Fees	\$300 per Encounter	Not Covered
Surgeon Fees <i>Services require Prior Authorization.</i>	\$300 per Encounter	Not Covered
Anesthesia	\$300 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	\$75 per Admission	Not Covered
Radiology Services	\$110 per Admission	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$300 per Encounter	Not Covered
Ancillary Services	\$300 per Encounter	Not Covered



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Benefit	In Network	Non Network
<b>Infertility Services</b>		
Diagnosis and Management <i>Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Treatment for Infertility	Not Covered	Not Covered
Artificial Insemination	Not Covered	Not Covered

Benefit	In Network	Non Network
<b>Infusion Therapy</b>		
Infusion Therapy .	50%	Not Covered

Benefit	In Network	Non Network
<b>Lab, X-Ray and Diagnostic Services</b>		
Laboratory Services	\$75 per Encounter	Not Covered
Radiology Services	\$110 per Encounter	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging <i>Services require Prior Authorization.</i>	\$300 per Encounter	Not Covered

Benefit	In Network	Non Network
<b>Mental Health and Substance Use Services</b>		
Inpatient Mental Health Care <i>Copay applies per day, up to 2 days. Services require Prior Authorization.</i>	\$3000 per Visit	Not Covered
Outpatient Mental Health Office Visit	\$0 per Visit	Not Covered
Inpatient Substance Use Services <i>Copay applies per day, up to 2 days. Services require Prior Authorization.</i>	\$3000 per Visit	Not Covered
Outpatient Substance Use Office Visits	\$0 per Visit	Not Covered
Other Outpatient Mental Health and Substance Use Services (non-office visits) <i>Services require Prior Authorization.</i>	\$300 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Outpatient Surgery</b>		
Outpatient Ambulatory Surgery <i>Services require Prior Authorization.</i>	\$1000 per Encounter	Not Covered
Surgeon Fees <i>Services require Prior Authorization.</i>	\$300 per Encounter	Not Covered



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Benefit	In Network	Non Network
Professional Fees <i>Services require Prior Authorization.</i>	\$300 per Encounter	Not Covered
Anesthesia	\$300 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	\$75 per Encounter	Not Covered
Radiology Services	\$110 per Encounter	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$300 per Encounter	Not Covered
Ancillary Services	\$300 per Encounter	Not Covered

Benefit	In Network	Non Network
<b>Outpatient Therapy Services – Rehabilitative and Habilitative</b>		
Rehabilitative Occupational and Rehabilitative Physical Therapy <i>Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Rehabilitative Speech Therapy <i>Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Cardiac Rehabilitation <i>Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Pulmonary Rehabilitation <i>Services require Prior Authorization.</i>	\$100 per Visit	Not Covered
Inhalation/Respiratory Therapy <i>Services require Prior Authorization.</i>	\$100 per Visit	Not Covered



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Benefit	In Network	Non Network
<b>Pediatric Dental Services for Dependent Children (through the end of the month in which they turn age 19)</b>		
Diagnostic and Preventive Services <i>Limited to 2 Exam(s) per Year.</i>	\$0 per Visit	Not Covered
Basic Services <i>The copay listed is the member copay for 1 surface, anterior restorative filling, please review the schedule of benefits for the copay on additional services</i>	\$50 per Visit	Not Covered
Major Services <i>The copay listed is the member copay for a crown, please review the schedule of benefits for the copay on additional services.</i>	\$690 per Visit	Not Covered
Medically Necessary Orthodontics and Prosthodontics <i>The copay listed is the member copay for comprehensive orthodontic treatment, please review the schedule of benefits for the copay on additional services.</i>	\$2800 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Pediatric Vision Services for Dependent Children (through the end of the month in which they turn age 19)</b>		
Pediatric Routine Eye Exam <i>Limited to 1 Exam(s) per Year.</i>	\$0 per Visit	Not Covered
Eyeglasses for Children <i>Limited to 1 pair of eyeglasses per calendar year including standard frames and standard lenses up to \$110, or contact lenses up to \$150.</i>	\$0	Not Covered
Low Vision Exam Children	Not Covered	Not Covered
Low Vision Aids	Not Covered	Not Covered

Benefit	In Network	Non Network
<b>Physician's Office Services</b>		
Primary Care Office Visits	No charge for first 1 visit(s) then \$50	Not Covered
Specialist Office Visits	No charge for first 1 visit(s) then \$100	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	50%	Not Covered
Surgeon Fees	\$300 per Visit	Not Covered
Anesthesia	\$300 per Visit	Not Covered



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Benefit	In Network	Non Network
Injections/Physician Administered Medications (with or without office visit)	50%	Not Covered

Benefit	In Network	Non Network
<b>Pregnancy/ Maternity Services</b>		
<i>Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean require pre- authorization. Services for newborn care after the mother's hospital discharge require Prior Authorization.</i>		
Prenatal/Postnatal Care	\$0 per Visit	Not Covered
Delivery Facility Fee <i>Copay applies per day, up to 2 days.</i>	\$3000 per Admission	Not Covered
Professional Fees	\$300 per Encounter	Not Covered
Surgeon Fees	\$300 per Encounter	Not Covered
Anesthesia	\$300 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	\$75 per Encounter	Not Covered
Radiology Services, including Ultrasound	\$110 per Encounter	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$300 per Encounter	Not Covered
Ancillary Services	\$300 per Encounter	Not Covered

<b>Prescription Drugs</b>		
<b>Retail Pharmacy</b>		
Tier	In Network	Out of Network
Preventive Medications	\$0	Not Covered
Preferred Generics	\$0/\$35	Not Covered
Preferred Brand and Non-Preferred Generics	\$200	Not Covered
Non-Preferred Brand and Non-Preferred Generics	50% after RX Deductible	Not Covered
Specialty Medications	50% after RX Deductible	Not Covered
<b>Mail Order</b>		
Tier	In Network	Out of Network
Preventive Medications	\$0	Not Covered
Preferred Generics	\$0/\$87.50	Not Covered
Preferred Brand and Non-Preferred Generics	\$500	Not Covered





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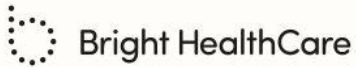
<b>Mail Order</b>		
<b>Tier</b>	<b>In Network</b>	<b>Out of Network</b>
Non-Preferred Brand and Non-Preferred Generics	50% after RX Deductible	Not Covered
Specialty Medications	50% after RX Deductible	Not Covered

<b>Benefit</b>	<b>In Network</b>	<b>Non Network</b>
<b>Preventive and Wellness Services</b>		
Preventive Care Services, Screenings and Immunizations	\$0 per Visit	Not Covered
Breast Cancer and Mammography Screening	\$0 per Visit	Not Covered
Visit <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations</a> for a list of Preventive and Wellness Services. You may also have additional preventive and wellness services available to you as required by state law.		

<b>Benefit</b>	<b>In Network</b>	<b>Non Network</b>
<b>Prosthetics</b>		
Prosthetic Limbs <i>Services require Prior Authorization.</i>	50%	Not Covered
Internally Implanted Prosthetic Devices <i>Services require Prior Authorization.</i>	50%	Not Covered
All other Prosthetic Devices <i>Services require Prior Authorization.</i>	50%	Not Covered
Wigs	\$0	Not Covered

<b>Benefit</b>	<b>In Network</b>	<b>Non Network</b>
<b>Sleep Studies</b>		
Sleep Studies <i>Services require Prior Authorization.</i>	50%	Not Covered

<b>Benefit</b>	<b>In Network</b>	<b>Non Network</b>
<b>Telehealth Virtual Care Services</b>		
Primary Care Telehealth Services	\$50 per Visit	Not Covered
Behavioral Health Telehealth Services	\$0 per Visit	Not Covered
Urgent Care Telehealth Services	\$50 per Visit	\$50 per Visit



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Benefit	
<b>Travel Expenses</b>	
Travel Expenses (Lodging and Food)	We will reimburse up to the Federal CONUS rate for lodging and food for the city in which services are received.
Mileage for use of a motor vehicle	We will reimburse in accordance with the current IRS allowance per mile for medical travel.
Airfare	We will reimburse airfare limited to the cost of coach round-trip airfare to the facility, unless Medically Necessary to travel in a different capacity.

Benefit	In Network	Non Network
<b>Urgent Care Services</b>		
Urgent Care Facility Fee	\$50 per Visit	\$50 per Visit
Surgeon Fees	\$300 per Visit	\$300 per Visit
Anesthesia	\$300 per Visit	\$300 per Visit
Laboratory Services	\$75 per Encounter	\$75 per Encounter
Radiology Services	\$110 per Encounter	\$110 per Encounter
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$300 per Encounter	\$300 per Encounter
Urgent Care Ancillary Charges	\$300 per Encounter	\$300 per Encounter