Section 1 - Schedule of Benefits
Gold Plan
(Who Pays What)

Plan Effective Date: January 1, 2020

This Policy is being issued by Bright Health Insurance Company of Florida, a subsidiary of Bright Health, Inc., 219 N. 2nd Street, Suite 401, Minneapolis, MN 55401.

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 IS A NETWORK-ONLY PLAN
This plan uses a network of Participating Providers to provide benefits to You. That means this Plan does not provide benefits for services You receive from Non-Network Providers, unless:
- You have a medical emergency;
- You are treated by a Non-Network Provider when you are receiving care at a Network Facility; or when
- We Pre-Authorize care to a Not-Network Provider because Medically Necessary services that You need are not available from a Network Provider.

You can review our provider network online at www.brighthealthplan.com, or You can contact Bright Health Customer Service at (855) 521-9335.

RIGHT TO CANCEL OR RETURN THIS POLICY
If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 10 days following your effective date. We will refund any fees you have paid and obtain refunds for any benefits that we have paid to you or your provider.

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

Copayment
A Copayment is a specific dollar amount that You must pay for certain Covered Health Services.

Coinsurance
A Coinsurance is a percentage of charges for Covered Health Services that must be paid by a Covered Person. Coinsurance amounts do not include Deductible, Copayment, or charges for non-covered services.

Maximum Out-of-Pocket
The Maximum Out-of-Pocket is the maximum dollar amount that a Covered Person may pay in combined Deductible, Copayment and Coinsurance amounts per Calendar Year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Maximum Out-of-Pocket amount. Once the Maximum Out-of-Pocket amount has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Coinsurance amounts for Covered Health Services received from a participating Bright Health Provider for the remainder of the Calendar Year. Payments to Non-Network Providers for charges that exceed Usual and Customary reimbursement do not apply to the Maximum Out-of-Pocket.

For policies with two or more people, each person's Individual Out-of-Pocket maximum applies to the Family Maximum Out-of-Pocket. Once a Covered Person has met his or her Maximum Out-of-Pocket, covered In-Network services will be paid at 100% for that person . Once two (2) or more people's combined Out-of-Pocket expenses reach the Family Maximum Out-of-Pocket, covered In-Network services for the family will be paid at 100%.

Limitations/Exclusions
Some limitations and exclusions are listed in this Schedule of Benefits. Refer to Section 8 - Limitations/Exclusions (What is Not Covered) for a more comprehensive listing and description of services or items that are limited or not covered by the Plan.

Deductible		**Maximum Out-of-Pocket**	
Individual	$2,700	Individual	$8,150
Family	$5,400	Family	$16,300

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Allergy Services

Allergy testing and services must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Services		$50 per visit	Not covered
Allergy Testing		20% after deductible	Not covered
Allergy Serum		20% after deductible	Not covered

Ambulatory Services - Outpatient Surgery

Outpatient Ambulatory Services must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Outpatient Ambulatory Surgery	Services require pre-authorization.	20% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	20% after deductible	Not covered

Autism Spectrum Disorder Services

Services for the treatment of Autism Spectrum Disorder must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Habilitative and Rehabilitative Outpatient Therapy Services (Speech, Occupational or Physical Therapy)	Services require pre-authorization.	20% after deductible	Not covered
Autism - Applied Behavioral Analysis	Services require pre-authorization.	20% after deductible	Not covered

Chemotherapy and Radiation Treatment

Chemotherapy and Radiation treatment must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Chemotherapy or Radiation Treatment	Services require pre-authorization.	20% after deductible	Not covered

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Clinical Trials

Services related to a Clinical Trial must be provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice. The facility and personnel providing the clinical trial treatment must have the experience and training to provide the treatment in a competent manner. Services apply a cost-share amount based on the type of physician or facility providing care.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*		*NON-NETWORK*
Primary Care Services	Services require pre-authorization.	$0 first 2 visits, then $25 per visit		Not covered
Specialty Care Services	Services require pre-authorization.	$50 per visit		Not covered
Hospital Services	Services require pre-authorization.	20% after deductible		Not covered
Laboratory & Radiology Services	Services require pre-authorization.	20% after deductible		Not covered
Prescription Drugs	Retail prescriptions include up to a 30-day supply of medications. Mail Order prescriptions include up to a 90-day supply of medications.	*RETAIL IN-NETWORK*	*MAIL ORDER IN-NETWORK*	*NON-NETWORK*
Preventive Medications (Tier 1)		No charge	No charge	Not covered
Generic (Tier 2)		$10 per prescription	$25 per prescription	Not covered
Preferred Brand (Tier 3)		$50 per prescription	$125 per prescription	Not covered
Non-Preferred Brand (Tier 4)		20% after deductible	20% after deductible	Not covered
Specialty Medications (Tier 5)		20% after deductible	20% after deductible	Not covered

Diabetic Shoes

Custom shoes for diabetics must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Custom Shoes for Diabetics	Services require pre-authorization.	20% after deductible	Not covered

Dialysis Services

Dialysis treatment must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Dialysis Treatment	Services require pre-authorization.	20% after deductible	Not covered

Durable Medical Equipment
Durable Medical Equipment and Devices must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Durable Medical Equipment and Devices	Services require pre-authorization.	20% after deductible	Not covered

Emergency Health Services and Urgent Care Services
Emergency Services received from Non-Network Providers will be covered at the In-Network benefit level. Payment to the Non-Network Provider will be based on Our Allowable Charge. Non-Network Providers may bill you for charges that exceed Bright Health's allowed charges.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Emergency Room Services (Facility charges)		20% after deductible	20% after deductible
Emergency Room Services (Ancillary charges)		20% after deductible	20% after deductible
Emergency Ambulance Transport (Ground/Air)		20% after deductible	20% after deductible
Urgent Care Center Services (Facility charges)		$75 per visit	Not covered
Urgent Care Center Services (Ancillary charges)		20% after deductible	Not covered

Genetic Testing and Counseling
Genetic Testing and Counseling Services must be received from a Participating Bright Health provider. Services received from Non Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Genetic Testing & Counseling	Services require pre-authorization.	20% after deductible	Not covered

Home Health Care
Home Health Care Services must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Home Health Services	Limited to 20 days per calendar year. Services require pre-authorization.	20% after deductible	Not covered

Hospice Care Services
Hospice Care must be received from a Participating Bright Health hospice facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Hospice Care	Services require pre-authorization.	20% after deductible	Not covered
Bereavement Support Services		$50 per visit	Not covered

Hospital Services
Services must be received from a Participating Bright Health hospital facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Hospital Services	Services require pre-authorization.	20% after deductible	Not covered
Inpatient Rehabilitation Facility Services	Services require pre-authorization.	20% after deductible	Not covered
Surgeon Fees	Services require pre-authorization.	20% after deductible	Not covered
Anesthesia	Services require pre-authorization.	20% after deductible	Not covered
Skilled Nursing Facility	Limited to 60 days per year; Services require pre-authorization.	20% after deductible	Not covered

Infusion Therapy
Infusion Therapy Services must be received from a Participating Bright Health provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Infusion Therapy	Services require pre-authorization.	20% after deductible	Not covered

Lab, X-Ray and Diagnostic Services

Diagnostic services must be received from a Participating Bright Health provider, hospital or outpatient facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnostic Outpatient Laboratory & Radiology & Testing		20% after deductible	Not covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	Services require pre-authorization.	20% after deductible	Not covered

Mental Health and Substance Abuse Services

Mental Health and Substance Abuse services must be received from a Participating Bright Health provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Mental Health Care	Services require pre-authorization.	20% after deductible	Not covered
Outpatient Mental Health Office Visit	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$50 per visit	Not covered
Inpatient Substance Abuse Services	Services require pre-authorization.	20% after deductible	Not covered
Outpatient Substance Abuse Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$50 per visit	Not covered
Outpatient Electroconvulsive Therapy (ECT)	Services require pre-authorization.	$50 per visit	Not covered

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Pediatric Dental Services

Pediatric Dental Services are available for dependent children under 19 years of age. Services must be received from a Participating Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Diagnostic and Preventive Services	Some Pediatric Dental services have limitations. Please refer to Your Certificate of Coverage Policy document for more information regarding covered services, limitations and exclusions of the Pediatric Dental plan.	No charge	No charge
Basic Services		50% after deductible	50% after deductible
Major Services			
Orthodontic Services *Medically necessary orthodontia and prosthodontics*			

Pediatric Vision Services

Pediatric Vision Services are available for dependent children under 19 years of age. Services and must be received from a Participating Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Pediatric Routine Eye Exam	Limited to 1 refractive eye exam per calendar year to determine the need for vision correction.	No charge	Not covered
Eyeglasses for Children	Limited to 1 pair of glasses per calendar year, including standard frames and standard lenses; or a one-year supply of contact lenses per calendar year.	No charge	Not covered

Pharmaceutical Products and Medical Supplies

Pharmaceutical Products and Medical Supplies are covered when provided by a Participating Provider. Services for Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Physician Administered Medications	Services require pre-authorization.	20% after deductible	Not covered
Prescribed Medical Supplies	Limited to the use of Durable Medical Equipment or in a Home Healthcare setting.	20% after deductible	Not covered
Ostomy Supplies		20% after deductible	Not covered

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Physician's Office Services

Physician services must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Primary Care Office Visits	Visits for No Charge include the office visit only. For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$0 first 2 visits, then $25 per visit	Not covered
Specialist Office Visits	For diagnostic lab or x-ray services, deductible and coinsurance apply. Hospital-owned clinics may charge a "clinic fee". These charges will apply deductible and coinsurance.	$50 per visit	Not covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)		20% after deductible	Not covered

Pregnancy - Maternity Services

Maternity services must be received from a Participating Bright Health provider or facility. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Inpatient Hospital Delivery and Birthing Center, including Prenatal and Postnatal Care and Midwife Services	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 pre-authorization.	20% after deductible	Not covered

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Prescription Drugs

Prescription Drugs must be received from a Participating Bright Health Pharmacy. Services received from a Non-Network Pharmacy will not be covered. To find a Participating Pharmacy, please visit our website at www.brighthealthplan.com, or call our Customer Service at (855) 521-9335.

SERVICE	*PLAN LIMITATIONS*	*RETAIL IN-NETWORK*	*MAIL ORDER IN-NETWORK*	*NON-NETWORK*
Preventive Medications and Formulary Contraceptive Medications and Devices (Tier 1)	Retail prescriptions include up to a 30-day supply of medications. Mail Order prescriptions include up to a 90-day supply of medications.	No Charge	No Charge	Not covered
Generic (Tier 2)		$10 per prescription	$25 per prescription	
Preferred Brand (Tier 3)		$50 per prescription	$125 per prescription	
Non-Preferred Brand (Tier 4)		20% after deductible	20% after deductible	
Specialty Medications (Tier 5)		20% after deductible	20% after deductible	

Preventive and Wellness Services

Preventive Care Services received from a Participating Bright Health Provider are covered at No Charge for You. Services received from Non-Network Providers will not be covered. Please refer to the What Is Covered section of Your Policy for a list of covered Preventive Health Services. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Wellness Exams (Adult & Child)	Covered Health Services under this section include preventive health care services in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, preventive services mandated by Colorado statute, women's preventive service guidelines published by the Health Resources and Services Administration in the U.S. Department of Health and Human Services and the Advisory Committee on Immunization Practices. Refer to your Certificate of Coverage for a list of covered services and applicable limitations.	No charge	Not covered
Immunizations		No charge	
Colorectal Cancer Screening		No charge	
Breast Cancer Screening		No charge	

Prosthetics
Prosthetic Devices must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Prosthetic Limbs	Services require pre-authorization.	20% after deductible	Not covered
Internally Implanted Prosthetic Devices	Services require pre-authorization.	20% after deductible	Not covered
All Other Prosthetic Devices	Services require pre-authorization.	20% after deductible	Not covered

Rehabilitative and Habilitative Services
Rehabilitative and Habilitative Services must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Occupational Therapy	Limited to 35 combined visits per year for Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. No therapy limitation for Occupational and Physical Therapy services for the treatment of autism. Services require pre-authorization.	20% after deductible	Not covered
Physical Therapy		20% after deductible	Not covered
Speech Therapy		20% after deductible	Not covered
Chiropractic Manipulations		20% after deductible	Not covered
Inpatient Habilitation/Rehabilitation	Services require pre-authorization.	20% after deductible	Not covered
Cardiac Rehabilitation	Services require pre-authorization.	20% after deductible	Not covered
Pulmonary Rehabilitation	Services require pre-authorization.	20% after deductible	Not covered

Sleep Studies
Sleep Studies must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Sleep Studies	Services require pre-authorization.	20% after deductible	Not covered

Temporomandibular Joint Disorder Treatment
Services for the treatment of Temporomandibular Joint Disorder must be received from a Participating Bright Health Provider. Services received from Non-Network Providers will not be covered. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a provider.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Services for the treatment of Temporomandibular Joint Disorder	Services require pre-authorization.	20% after deductible	Not covered

Transplantation Services
Transplantation Services must be received from a Participating Bright Health Center of Excellence. Please visit our website at www.brighthealthplan.com or call Bright Health Customer Service at (855) 521-9335 to locate a Participating Provider or Facility.

SERVICE	*PLAN LIMITATIONS*	*IN-NETWORK*	*NON-NETWORK*
Organ and Tissue Transplants	Services require pre-authorization.	20% after deductible	Not covered

Travel Expenses
Pre-arranged travel expenses, including meals and lodging when it is medically necessary, as determined by Us, for a Covered Person to receive care from a designated facility that is located more than 100 miles from the Covered Person's home are reimbursable by the Plan. Care must be directed by the Plan.

SERVICE	*PLAN LIMITATIONS*	*YOUR COST*
Travel Expenses (Lodging and Food)	Plan will reimburse up to Federal CONUS rate for lodging and food for the city in which services are received.	No charge
Mileage for use of a motor vehicle	Plan will reimburse in accordance with the current IRS allowance per mile for medical travel.	No charge
Airfare	Plan reimbursement is limited to the cost of a round-trip coach airfare to the facility, unless medically necessary to travel in a different capacity.	No charge