



**Schedule of Benefits**  
**Bronze 8550**  
**(Who Pays What)**  
**From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

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 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
- We authorize services out-of-network because the Medically Necessary services that You need are not available from a Participating Provider.

You can review our provider network online at [www.brighthealthplan.com](http://www.brighthealthplan.com), or You can contact Bright Health Customer Service at (855) 827-4448 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 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. Refer to Your Policy to see how charges from Non-Network Providers may be covered.

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 the Benefits/Coverage (What is Covered) and Limitations/Exclusions (What is Not Covered) sections of Your policy for a more comprehensive listing and description of services or items that are limited or not covered by the Plan.



**Schedule of Benefits**  
**Bronze 8550**  
**(Who Pays What)**  
**From 01/01/2021 through 12/31/2021**

Bright Health Company  
 of North Carolina

General Cost Share & Features	In Network	Non Network
<b>Deductible:</b> - Per Plan Year - Medical/Rx <i>Some services do not apply to the deductible, as indicated below.</i>	\$8,550/Individual; \$17,100/Family	Not covered
<b>Out-of-Pocket Maximum:</b> - Per Plan Year	\$8,550/Individual; \$17,100/Family	Not covered

Benefit	In Network	Non Network
<b>Allergy Services</b>		
Physician Services	0% after deductible	Not covered
Allergy Testing	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Ambulatory Services – Outpatient Surgery</b>		
Outpatient Ambulatory Surgery <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Surgeon Fees <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Bariatric Surgery</b>		
Bariatric Surgery <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Surgeon Fees <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Chemotherapy &amp; Radiation Treatment</b>		
Chemotherapy or Radiation Treatment <i>Services require pre-authorization.</i>	0% after deductible	Not covered



**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
<b>Chiropractic Care</b>		
Spinal Manipulations <i>Limited to 30 combined visits per year for Occupational Therapy, Physical Therapy, and Chiropractic Manipulations.</i>	0% after deductible	Not covered
Diagnostic X-ray Services	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Clinical Trials – All services related to Clinical Trials require pre-authorization</b>		
Primary Care Services	\$25 first 2 visits, then 0% after deductible	Not covered
Specialty Care Services	0% after deductible	Not covered
Hospital Services	0% after deductible	Not covered
Laboratory Services	0% after deductible	Not covered
Radiology Services	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Diabetic Shoes</b>		
Custom Shoes for Diabetics <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Dialysis Services</b>		
Dialysis Treatment <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Durable Medical Equipment</b>		
Durable Medical Equipment and Devices <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Orthotic Devices for Correction of Positional Plagiocephaly <i>Services require pre-authorization. Limited to 1 device per lifetime.</i>	0% after deductible	Not covered



**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
<b>Emergency Health Services and Urgent Care Services</b>		
Emergency Room Services (Facility charges) <i>See Lab, X-Ray and Diagnostic Services for additional charges that may apply.</i>	0% after deductible	0% after deductible
Emergency Room Services (Ancillary charges)	0% after deductible	0% after deductible
Emergency Ambulance Transport (Ground/Air)	0% after deductible	0% after deductible
Urgent Care Center Services (Facility charges) <i>See Lab, X-Ray and Diagnostic Services for additional charges that may apply.</i>	\$50 per visit	\$50 per visit

Benefit	In Network	Non Network
<b>Genetic Testing and Counseling</b>		
Genetic Testing and Counseling <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Hearing Services</b>		
Hearing Exam and Testing <i>Limited to 1 screening per year to detect the need for hearing correction.</i>	0% after deductible	Not covered
Hearing Aids for Children <i>Limited to members under age 22; Plan will cover the one hearing aid per hearing impaired ear every 36 months.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Home Health Care</b>		
Home Health Services <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Hospice Care Services</b>		
Hospice Care <i>Services require pre-authorization.</i>	0% after deductible	Not covered



**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
Bereavement Support Services	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Hospital Services</b>		
Inpatient Hospital Services <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Inpatient Habilitation/ Rehabilitation Facility Services <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Surgeon Fees <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Skilled Nursing Facility <i>Services require pre-authorization. Limited to 60 days per calendar year.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Infertility Services</b>		
Diagnosis and Management <i>Services require pre-authorization. Coverage includes services for diagnosis and treatment of involuntary infertility.</i>	0% after deductible	Not covered
Treatment for Infertility <i>Services require pre-authorization. Services to reverse voluntary sterilization or infertility are not covered. Limited to 3 treatments per lifetime.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Infusion Therapy</b>		
Infusion Therapy <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Lab, X-Ray and Diagnostic Services</b>		
Laboratory Services	0% after deductible	Not covered
Radiology Services	0% after deductible	Not covered



**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Mental Health and Substance Abuse Services</b>		
Inpatient Mental Health Care <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Outpatient Mental Health Office Visit	0% after deductible	Not covered
Inpatient Substance Abuse Services <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Outpatient Substance Abuse Office Visits	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Outpatient Therapy Services – Rehabilitative and Habilitative</b>		
Rehabilitative Occupational and Rehabilitative Physical Therapy <i>Services require pre-authorization. Limited to 30 combined visits per year for Occupational Therapy, Physical Therapy, and Chiropractic Manipulations.</i>	0% after deductible	Not covered
Rehabilitative Speech Therapy <i>Services require pre-authorization. Limited to 30 visits per calendar year.</i>	0% after deductible	Not covered
Cardiac Rehabilitation <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Pulmonary Rehabilitation <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Pediatric Dental Services</b>		
Diagnostic and Preventive Services <i>Limited to 2 visits per calendar year.</i>	No charge	Not covered
Basic Services	0% after deductible	Not covered
Major Services	0% after deductible	Not covered



**Schedule of Benefits**  
**Bronze 8550**  
**(Who Pays What)**  
**From 01/01/2021 through 12/31/2021**

Bright Health Company  
 of North Carolina

Benefit	In Network	Non Network
Medically Necessary Orthodontics and Prosthodontics Services require pre-authorization.	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Pediatric Vision Services</b>		
Pediatric Routine Eye Exam <i>Limited to 1 refractive eye exam per calendar year through the end of the month in which the member turns 19.</i>	No charge	Not covered
Eyeglasses for Children <i>Limited to 1 pair of eyeglasses every calendar year, including standard frames and standard lenses or a one-year supply of contact lenses through the end of the month in which the member turns 19.</i>	No charge	Not covered
Pediatric Low Vision Evaluation <i>Limited to 1 comprehensive evaluation every 5 years. Services require pre-authorization.</i>	No charge	Not covered
Pediatric Low Vision Aids <i>Services require pre-authorization.</i>	No charge	Not covered

Benefit	In Network	Non Network
<b>Pharmaceutical Products and Medical Supplies</b>		
Physician Administered Medications <i>Services require pre-authorization.</i>	0% after deductible	Not covered
Prescribed Medical Supplies	0% after deductible	Not covered
Ostomy Supplies	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Physician's Office Services</b>		
Primary Care Office Visits	\$25 first 2 visits, then 0% after deductible	Not covered
Specialist Office Visits	0% after deductible	Not covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	0% after deductible	Not covered



**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
<b>Pregnancy – Maternity Services</b>		
Inpatient Hospital Delivery and Birthing Center, including Prenatal and Postnatal Care and Midwife Services <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 pre-authorization.</i>	0% after deductible	Not covered

<b>Prescription Drugs</b>		
<b>Retail Pharmacy</b>		
Tier	In Network	Out of Network
Tier 1: Preventive Medications	No charge	Not covered
Tier 2: Preferred Generics	\$25 per prescription	Not covered
Tier 3: Preferred Medications	0% after deductible	Not covered
Tier 4: Non-Preferred Medications	0% after deductible	Not covered
Tier 5: Specialty Medications	0% after deductible	Not covered
<b>Mail Order</b>		
Tier	In Network	Out of Network
Tier 1: Preventive Medications	No charge	Not covered
Tier 2: Preferred Generics	\$62.50 per prescription	Not covered
Tier 3: Preferred Medications	0% after deductible	Not covered
Tier 4: Non-Preferred Medications	0% after deductible	Not covered
Tier 5: Specialty Medications	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Preventive and Wellness Services</b>		
Preventive Care Services, Screenings and Immunizations	No charge	Not covered

Benefit	In Network	Non Network
<b>Prosthetics</b>		
Prosthetic Limbs <i>Services require pre-authorization.</i>	0% after deductible	Not covered





**Schedule of Benefits  
Bronze 8550  
(Who Pays What)  
From 01/01/2021 through 12/31/2021**

Bright Health Company  
of North Carolina

Benefit	In Network	Non Network
Internally Implanted Prosthetic Devices <i>Services require pre-authorization.</i>	0% after deductible	Not covered
All other Prosthetic Devices <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Sleep Studies</b>		
Sleep Studies <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Temporomandibular Joint Disorder Treatment</b>		
Services for the treatment of Temporomandibular Joint Disorder <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	In Network	Non Network
<b>Transplantation Services</b>		
Organ and Tissue Transplants <i>Services require pre-authorization.</i>	0% after deductible	Not covered

Benefit	
<b>Travel Expenses</b>	
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.
Mileage for use of a motor vehicle	Plan will reimburse in accordance with the current IRS allowance per mile for medical travel.
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.