Schedule of Benefits
Silver $0 Deductible
(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, 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
Silver $0 Deductible
(Who Pays What)
From 01/01/2021 through 12/31/2021

General Cost Share & Features	In Network	Non Network
Deductible: - Per Plan Year - Medical/Rx *Some services do not apply to the deductible, as indicated below.*	$0/Individual; $0/Family	Not covered
Out-of-Pocket Maximum: - Per Plan Year	$900/Individual; $1,800/Family	Not covered

Benefit	In Network	Non Network
Allergy Services		
Physician Services	$10 per visit	Not covered
Allergy Testing	10% coinsurance	Not covered

Benefit	In Network	Non Network
Ambulatory Services – Outpatient Surgery		
Outpatient Ambulatory Surgery *Services require pre-authorization.*	$200 per visit	Not covered
Surgeon Fees *Services require pre-authorization.*	$50 per visit	Not covered

Benefit	In Network	Non Network
Bariatric Surgery		
Bariatric Surgery *Services require pre-authorization.*	10% coinsurance	Not covered
Surgeon Fees *Services require pre-authorization.*	$50 per visit	Not covered

Benefit	In Network	Non Network
Chemotherapy & Radiation Treatment		
Chemotherapy or Radiation Treatment *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Chiropractic Care		
Spinal Manipulations *Limited to 30 combined visits per year for Occupational Therapy, Physical Therapy, and Chiropractic Manipulations.*	$10 per visit	Not covered
Diagnostic X-ray Services	$10 per day	Not covered

Benefit	In Network	Non Network
Clinical Trials – *All services related to Clinical Trials require pre-authorization*		
Primary Care Services	$5 per vist	Not covered
Specialty Care Services	$10 per visit	Not covered
Hospital Services	10% coinsurance	Not covered
Laboratory Services	$5 per day	Not covered
Radiology Services	$10 per day	Not covered

Benefit	In Network	Non Network
Diabetic Shoes		
Custom Shoes for Diabetics *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Dialysis Services		
Dialysis Treatment *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Durable Medical Equipment		
Durable Medical Equipment and Devices *Services require pre-authorization.*	10% coinsurance	Not covered
Orthotic Devices for Correction of Positional Plagiocephaly *Services require pre-authorization.* *Limited to 1 device per lifetime.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Emergency Health Services and Urgent Care Services		
Emergency Room Services (Facility charges) *See Lab, X-Ray and Diagnostic Services for additional charges that may apply.*	$200 per visit	$200 per visit
Emergency Room Services (Ancillary charges)	10% coinsurance	10% coinsurance
Emergency Ambulance Transport (Ground/Air)	10% coinsurance	10% coinsurance
Urgent Care Center Services (Facility charges) *See Lab, X-Ray and Diagnostic Services for additional charges that may apply.*	$5 per visit	$5 per visit

Benefit	In Network	Non Network
Genetic Testing and Counseling		
Genetic Testing and Counseling *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Hearing Services		
Hearing Exam and Testing *Limited to 1 screening per year to detect the need for hearing correction.*	$10 per visit	Not covered
Hearing Aids for Children *Limited to members under age 22; Plan will cover the one hearing aid per hearing impaired ear every 36 months.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Home Health Care		
Home Health Services *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Hospice Care Services		
Hospice Care *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Bereavement Support Services	$5 per visit	Not covered

Benefit	In Network	Non Network
Hospital Services		
Inpatient Hospital Services *Services require pre-authorization.*	10% coinsurance	Not covered
Inpatient Habilitation/ Rehabilitation Facility Services *Services require pre-authorization.*	10% coinsurance	Not covered
Surgeon Fees *Services require pre-authorization.*	$50 per visit	Not covered
Skilled Nursing Facility *Services require pre-authorization. Limited to 60 days per calendar year.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Infertility Services		
Diagnosis and Management *Services require pre-authorization. Coverage includes services for diagnosis and treatment of involuntary infertility.*	10% coinsurance	Not covered
Treatment for Infertility *Services require pre-authorization. Services to reverse voluntary sterilization or infertility are not covered. Limited to 3 treatments per lifetime.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Infusion Therapy		
Infusion Therapy *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Lab, X-Ray and Diagnostic Services		
Laboratory Services	$5 per day	Not covered
Radiology Services	$10 per day	Not covered

Benefit	In Network	Non Network
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging *Services require pre-authorization.*	$50 per visit	Not covered

Benefit	In Network	Non Network
Mental Health and Substance Abuse Services		
Inpatient Mental Health Care *Services require pre-authorization.*	10% coinsurance	Not covered
Outpatient Mental Health Office Visit	$5 per visit	Not covered
Inpatient Substance Abuse Services *Services require pre-authorization.*	10% coinsurance	Not covered
Outpatient Substance Abuse Office Visits	$5 per visit	Not covered

Benefit	In Network	Non Network
Outpatient Therapy Services – Rehabilitative and Habilitative		
Rehabilitative Occupational and Rehabilitative Physical Therapy *Services require pre-authorization. Limited to 30 combined visits per year for Occupational Therapy, Physical Therapy, and Chiropractic Manipulations.*	$10 per visit	Not covered
Rehabilitative Speech Therapy *Services require pre-authorization. Limited to 30 visits per calendar year.*	$10 per visit	Not covered
Cardiac Rehabilitation *Services require pre-authorization.*	$10 per visit	Not covered
Pulmonary Rehabilitation *Services require pre-authorization.*	$10 per visit	Not covered

Benefit	In Network	Non Network
Pediatric Dental Services		
Diagnostic and Preventive Services *Limited to 2 visits per calendar year.*	No charge	Not covered
Basic Services	50% coinsurance	Not covered
Major Services	50% coinsurance	Not covered

Benefit	In Network	Non Network
Medically Necessary Orthodontics and Prosthodontics *Services require pre-authorization.*	50% coinsurance	Not covered

Benefit	In Network	Non Network
Pediatric Vision Services		
Pediatric Routine Eye Exam *Limited to 1 refractive eye exam per calendar year through the end of the month in which the member turns 19.*	No charge	Not covered
Eyeglasses for Children *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.*	No charge	Not covered
Pediatric Low Vision Evaluation *Limited to 1 comprehensive evaluation every 5 years.* *Services require pre-authorization.*	No charge	Not covered
Pediatric Low Vision Aids *Services require pre-authorization.*	No charge	Not covered

Benefit	In Network	Non Network
Pharmaceutical Products and Medical Supplies		
Physician Administered Medications *Services require pre-authorization.*	10% coinsurance	Not covered
Prescribed Medical Supplies	10% coinsurance	Not covered
Ostomy Supplies	10% coinsurance	Not covered

Benefit	In Network	Non Network
Physician's Office Services		
Primary Care Office Visits	$5 per vist	Not covered
Specialist Office Visits	$10 per visit	Not covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	10% coinsurance	Not covered

Benefit	In Network	Non Network
Pregnancy – Maternity Services		
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.*	10% coinsurance	Not covered

Prescription Drugs		
Retail Pharmacy		
Tier	**In Network**	**Out of Network**
Tier 1: Preventive Medications	No charge	Not covered
Tier 2: Preferred Generics	$5 per prescription	Not covered
Tier 3: Preferred Medications	$25 per prescription	Not covered
Tier 4: Non-Preferred Medications	$50 per prescription	Not covered
Tier 5: Specialty Medications	10% coinsurance	Not covered
Mail Order		
Tier	**In Network**	**Out of Network**
Tier 1: Preventive Medications	No charge	Not covered
Tier 2: Preferred Generics	$12.50 per prescription	Not covered
Tier 3: Preferred Medications	$62.50 per prescription	Not covered
Tier 4: Non-Preferred Medications	$125 per prescription	Not covered
Tier 5: Specialty Medications	10% coinsurance	Not covered

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

Benefit	In Network	Non Network
Prosthetics		
Prosthetic Limbs *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Internally Implanted Prosthetic Devices *Services require pre-authorization.*	10% coinsurance	Not covered
All other Prosthetic Devices *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Sleep Studies		
Sleep Studies *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Temporomandibular Joint Disorder Treatment		
Services for the treatment of Temporomandibular Joint Disorder *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	In Network	Non Network
Transplantation Services		
Organ and Tissue Transplants *Services require pre-authorization.*	10% coinsurance	Not covered

Benefit	
Travel Expenses	
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.