Schedule of Benefits
Super Silver $0 Deductible 4
(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, or You can contact Bright HealthCare 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 HealthCare pays any benefits for Covered Health Services. The Deductible amount does not include Coinsurance, 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.

Coinsurance
Coinsurance is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services. Coinsurance amounts accumulate towards Your Out-of-Pocket Maximum.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance, or Copayments You pay in a calendar year. All Deductible, Copayment and Coinsurance 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 Coinsurance 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.

General Cost Share & Features	In Network	Non Network
Deductible: Per Plan Year - Medical	$0/Individual; $0/Family	Not Covered
Out-of-Pocket Maximum: - Per Plan Year	$1,000/Individual; $2,000/Family	Not Covered

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Benefit	In Network	Non Network
Allergy Services		
Physician Services	25%	Not Covered
Allergy Testing	25%	Not Covered
Allergy Serum	25%	Not Covered

Benefit	In Network	Non Network
Autism Spectrum Disorder Services		
Outpatient Therapy Services *Services require Prior Authorization. Limited to 35 Days per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Services require Prior Authorization.*	25%	Not Covered
Autism - Applied Behavioral Analysis *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Chemotherapy & Radiation Treatment		
Chemotherapy Treatment *Services require Prior Authorization.*	25%	Not Covered
Radiation Treatment *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Chiropractic Care		
Spinal Manipulations *Limited to 35 Days per Year. Combined limit for Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic Manipulations.*	25%	Not Covered
Diagnostic X-ray Services	25%	Not Covered

Benefit	In Network	Non Network
Dialysis Services		
Dialysis Treatment *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Durable Medical Equipment		
Durable Medical Equipment and Devices *Services require Prior Authorization.*	25%	Not Covered
Diabetic Shoes *Services require Prior Authorization.*	25%	Not Covered
Ostomy Supplies *Services require Prior Authorization.*	25%	Not Covered
Equipment for the treatment of Positional Plagiocephaly *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Emergency Health Services		
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.		
Emergency Room Facility	25%	25%
Emergency Room Physician/ Surgeon charges	25%	25%
Professional Fees	25%	25%
Anesthesia	25%	25%
Laboratory Services	25%	25%
Radiology Services	25%	25%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	25%
Emergency Room Ancillary Charges	25%	25%
Emergency Ambulance Transport (Ground/Air/Water)	25%	25%

Benefit	In Network	Non Network
Genetic Testing and Counseling		
Genetic Testing and Counseling *Services require Prior Authorization.*	25%	Not Covered

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

Benefit	In Network	Non Network
Hearing Exam/Evaluation	25%	Not Covered
Hearing Aids	Not Covered	Not Covered

Benefit	In Network	Non Network
Home Health Care		
Home Health *Limited to 20 Days per Year.* *Services require Prior Authorization.*	25%	Not Covered
Home Infusion Therapy *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Hospice Care Services		
Hospice Care	25%	Not Covered
Bereavement Support Services	25%	Not Covered

Benefit	In Network	Non Network
Hospital Services & Inpatient Surgery, including Organ & Tissue Transplants *All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.*		
Inpatient Hospital Facility/Surgery *Services require Prior Authorization.*	25%	Not Covered
Inpatient Habilitation/ Rehabilitation Facility *Services require Prior Authorization.*	25%	Not Covered
Skilled Nursing Facility *Limited to 60 Days per Year.* *Services require Prior Authorization.*	25%	Not Covered
Professional Fees	25%	Not Covered
Surgeon Fees *Services require Prior Authorization.*	25%	Not Covered
Anesthesia	25%	Not Covered
Laboratory Services, including pre-admission testing	25%	Not Covered
Radiology Services	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	25%	Not Covered

Benefit	In Network	Non Network
Infertility Services		
Diagnosis and Management *Services require Prior Authorization.*	25%	Not Covered
Treatment for Infertility	Not Covered	Not Covered
Artificial Insemination	Not Covered	Not Covered

Benefit	In Network	Non Network
Infusion Therapy		
Infusion Therapy *Services require Prior Authorization..*	25%	Not Covered

Benefit	In Network	Non Network
Lab, X-Ray and Diagnostic Services		
Laboratory Services	25%	Not Covered
Radiology Services	25%	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Mental Health and Substance Use Services		
Inpatient Mental Health Care *Services require Prior Authorization.*	25%	Not Covered
Outpatient Mental Health Office Visit	25%	Not Covered
Inpatient Substance Use Services *Services require Prior Authorization.*	25%	Not Covered
Outpatient Substance Use Office Visits	25%	Not Covered
Other Outpatient Mental Health and Substance Use Services (non-office visits) *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Outpatient Surgery		
Outpatient Ambulatory Surgery *Services require Prior Authorization.*	25%	Not Covered
Surgeon Fees *Services require Prior Authorization.*	25%	Not Covered
Professional Fees *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Anesthesia	25%	Not Covered
Laboratory Services, including pre-admission testing	25%	Not Covered
Radiology Services	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	25%	Not Covered

Benefit	In Network	Non Network
Outpatient Therapy Services – Rehabilitative and Habilitative		
Rehabilitative Occupational and Rehabilitative Physical Therapy *Limited to 35 Days per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Services require Prior Authorization.*	25%	Not Covered
Rehabilitative Speech Therapy *Limited to 35 Days per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Services require Prior Authorization.*	25%	Not Covered
Cardiac Rehabilitation *Services require Prior Authorization.*	25%	Not Covered
Pulmonary Rehabilitation *Services require Prior Authorization.*	25%	Not Covered
Inhalation/Respiratory Therapy *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Pediatric Dental Services for Dependent Children (through the end of the month in which they turn age 19)		
Diagnostic and Preventive Services *The member copay listed is for a routine preventative visit, please review the schedule of benefits for the copay on additional services*	$0 per Visit	Not Covered
Basic Services *The copay listed is the member copay for 1 surface, anterior restorative filing, please review the schedule of benefits for the copay on additional services*	$50 per Visit	Not Covered

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Major Services *The copay listed is the member copay for a crown, please review the schedule of benefits for the copay on additional services.*	$690 per Visit	Not Covered
Medically Necessary Orthodontics and Prosthodontics *The copay listed is the member copay for comprehensive orthodontic treatment, please review the schedule of benefits for the copay on additional services.*	$2800 per Visit	Not Covered

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

Benefit	In Network	Non Network
Physician's Office Services		
Primary Care Office Visits	$5 per Visit	Not Covered
Specialist Office Visits	25%	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	25%	Not Covered
Surgeon Fees	25%	Not Covered
Anesthesia	25%	Not Covered
Injections/Physician Administered Medications (with or without office visit)	25%	Not Covered

Benefit	In Network	Non Network
Pregnancy/ Maternity 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 Prior Authorization.		
Prenatal/Postnatal Care	$0 per Visit	Not Covered
Delivery Facility Fee	25%	Not Covered
Professional Fees	25%	Not Covered
Surgeon Fees	25%	Not Covered
Anesthesia	25%	Not Covered
Laboratory Services, including pre-admission testing	25%	Not Covered
Radiology Services, including Ultrasound	25%	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	Not Covered
Ancillary Services	25%	Not Covered

Prescription Drugs		
Retail Pharmacy		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$5	Not Covered
Preferred Brand and Non-Preferred Generics	25%	Not Covered
Non-Preferred Brand and Non-Preferred Generics	25%	Not Covered
Specialty Medications	25%	Not Covered
Mail Order		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$12.50	Not Covered
Preferred Brand and Non-Preferred Generics	25%	Not Covered
Non-Preferred Brand and Non-Preferred Generics	25%	Not Covered
Specialty Medications	25%	Not Covered

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Preventive and Wellness Services		
Preventive Care Services, Screenings and Immunizations	$0 per Visit	Not Covered
Breast Cancer and Mammography Screening	$0 per Visit	Not Covered
Visit https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations 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.		

Benefit	In Network	Non Network
Prosthetics		
Prosthetic Limbs *Services require Prior Authorization.*	25%	Not Covered
Internally Implanted Prosthetic Devices *Services require Prior Authorization.*	25%	Not Covered
All other Prosthetic Devices *Services require Prior Authorization.*	25%	Not Covered
Wigs	$0	Not Covered

Benefit	In Network	Non Network
Sleep Studies		
Sleep Studies *Services require Prior Authorization.*	25%	Not Covered

Benefit	In Network	Non Network
Telehealth Virtual Care Services		
Primary Care Telehealth Services	$5 per Visit	Not Covered
Behavioral Health Telehealth Services	25%	Not Covered
Urgent Care Telehealth Services	$20 per Visit	$20 per Visit

Benefit	
Travel Expenses	
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.

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Benefit	In Network	Non Network
Urgent Care Services		
Urgent Care Facility Fee	$20 per Visit	$20 per Visit
Surgeon Fees	25%	25%
Anesthesia	25%	25%
Laboratory Services	25%	25%
Radiology Services	25%	25%
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	25%	25%
Urgent Care Ancillary Charges	25%	25%