



**Schedule of Benefits**  
**Peak Silver \$0 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 (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**

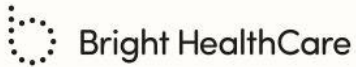
The Out-of-Pocket Maximum is the maximum amount of Deductible, Coinsurance, or Copayments You pay in a calendar year. All Deductible, Copayment and Coinsurance payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered 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.

<b>General Cost Share &amp; Features</b>	<b>In Network</b>	<b>Non Network</b>
<b>Deductible:</b> Per Plan Year - Medical	\$0/Individual; \$0/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	\$30 per Visit	Not Covered
Allergy Testing	40%	Not Covered
Allergy Serum	40%	Not Covered

Benefit	In Network	Non Network
<b>Autism Spectrum Disorder Services</b>		
Outpatient Therapy Services <i>Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Autism - Applied Behavioral Analysis <i>Services require Prior Authorization.</i>	\$200 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Chemotherapy &amp; Radiation Treatment</b>		
Chemotherapy Treatment <i>Services require Prior Authorization.</i>	40%	Not Covered
Radiation Treatment <i>Services require Prior Authorization.</i>	40%	Not Covered

Benefit	In Network	Non Network
<b>Chiropractic Care</b>		
Spinal Manipulations <i>Limited to 20 Visit(s) per Year.</i>	\$60 per Visit	Not Covered
Diagnostic X-ray Services	\$100 per Encounter	Not Covered

Benefit	In Network	Non Network
<b>Dialysis Services</b>		
Dialysis Treatment <i>Services require Prior Authorization.</i>	40%	Not Covered

Benefit	In Network	Non Network
<b>Durable Medical Equipment</b>		
Durable Medical Equipment and Devices <i>Services require Prior Authorization.</i>	40%	Not Covered
Diabetic Shoes <i>Services require Prior Authorization.</i>	40%	Not Covered
Ostomy Supplies <i>Services require Prior Authorization.</i>	40%	Not Covered



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Benefit	In Network	Non Network
Equipment for the treatment of Positional Plagiocephaly <i>Services require Prior Authorization.</i>	40%	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	\$750 per Admission	\$750 per Admission
Emergency Room Physician/ Surgeon charges	\$200 per Admission	\$200 per Admission
Professional Fees	\$200 per Admission	\$200 per Admission
Anesthesia	\$200 per Encounter	\$200 per Encounter
Laboratory Services	\$50 per Admission	\$50 per Admission
Radiology Services	\$100 per Admission	\$100 per Admission
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$200 per Encounter	\$200 per Encounter
Emergency Room Ancillary Charges	\$200 per Encounter	\$200 per Encounter
Emergency Ambulance Transport (Ground/Air/Water)	40%	40%

Benefit	In Network	Non Network
<b>Genetic Testing and Counseling</b>		
Genetic Testing and Counseling <i>Services require Prior Authorization.</i>	40%	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
Hearing Exam/Evaluation	\$30 per Visit	Not Covered
Hearing Aids <i>Limited to 1 Item(s) per Benefit Period. Benefit period is 5 years. Services require Prior Authorization.</i>	40%	Not Covered



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Benefit	In Network	Non Network
<b>Home Health Care</b>		
Home Health <i>Limited to 28 Hours per Week. Limit combined with Private Duty Nursing. Services require Prior Authorization.</i>	40%	Not Covered
Home Infusion Therapy	40%	Not Covered

Benefit	In Network	Non Network
<b>Hospice Care Services</b>		
Hospice Care	40%	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, and Gender Dysphoria and Gender Transition Services</b> <i>All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.</i>		
Inpatient Hospital Facility/Surgery <i>Services require Prior Authorization.</i>	40%	Not Covered
Inpatient Habilitation/Rehabilitation Facility <i>Services require Prior Authorization.</i>	\$60 per Admission	Not Covered
Skilled Nursing Facility <i>Limited to 100 Days per Year. Copay applies per day, up to 2 days.</i>	40%	Not Covered
Professional Fees	40%	Not Covered
Surgeon Fees <i>Services require Prior Authorization.</i>	40%	Not Covered
Anesthesia	40%	Not Covered
Laboratory Services, including pre-admission testing	\$50 per Admission	Not Covered
Radiology Services	\$100 per Admission	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$200 per Encounter	Not Covered
Ancillary Services	40%	Not Covered

Benefit	In Network	Non Network
<b>Infertility Services</b>		
Diagnosis and Management <i>Services require Prior Authorization.</i>	\$30 per Visit	Not Covered
Treatment for Infertility	40%	Not Covered
Artificial Insemination	40%	Not Covered



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Benefit	In Network	Non Network
<b>Infusion Therapy</b>		
Infusion Therapy .	40%	Not Covered

Benefit	In Network	Non Network
<b>Lab, X-Ray and Diagnostic Services</b>		
Laboratory Services	\$50 per Encounter	Not Covered
Radiology Services	\$100 per Encounter	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging <i>Services require Prior Authorization.</i>	\$200 per Encounter	Not Covered

Benefit	In Network	Non Network
<b>Mental Health and Substance Use Services</b>		
Inpatient Mental Health Care <i>Services require Prior Authorization.</i>	40%	Not Covered
Outpatient Mental Health Office Visit	\$0 per Visit	Not Covered
Inpatient Substance Use Services <i>Services require Prior Authorization</i>	40%	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>	\$200 per Visit	Not Covered

Benefit	In Network	Non Network
<b>Outpatient Surgery</b>		
Outpatient Ambulatory Surgery <i>Services require Prior Authorization.</i>	\$750 per Encounter	Not Covered
Surgeon Fees <i>Services require Prior Authorization.</i>	\$200 per Encounter	Not Covered
Professional Fees <i>Services require Prior Authorization.</i>	\$200 per Encounter	Not Covered
Anesthesia	\$200 per Encounter	Not Covered
Laboratory Services, including pre-admission testing	\$50 per Encounter	Not Covered
Radiology Services	\$100 per Encounter	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$200 per Encounter	Not Covered



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Benefit	In Network	Non Network
Ancillary Services	\$200 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 40 Visit(s) per Year. Limited to 20 visits per therapy type per year. Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Rehabilitative Speech Therapy <i>Limited to 20 Visit(s) per Year. Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Cardiac Rehabilitation <i>Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Pulmonary Rehabilitation <i>Services require Prior Authorization.</i>	\$60 per Visit	Not Covered
Inhalation/Respiratory Therapy <i>Services require Prior Authorization.</i>	\$60 per Visit	Not Covered

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>See Schedule of Benefits for plan limits. Benefits are available up to the end of the month in which the member turns 19.</i>	50%	Not Covered
Major Services <i>See Schedule of Benefits for plan limits.</i>	50%	Not Covered
Medically Necessary Orthodontics and Prosthodontics <i>Medically necessary Orthodontia only. Benefits are available up to the end of the month in which the member turns 19.</i>	50%	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



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Benefit	In Network	Non Network
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	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 2 visit(s) then \$30	Not Covered
Specialist Office Visits	\$30 per Visit	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	40%	Not Covered
Surgeon Fees	\$200 per Visit	Not Covered
Anesthesia	\$200 per Visit	Not Covered
Injections/Physician Administered Medications (with or without office visit)	40%	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>Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for cesarean delivery require pre-authorization.</i>	40%	Not Covered
Professional Fees	40%	Not Covered
Surgeon Fees	40%	Not Covered
Anesthesia	40%	Not Covered
Laboratory Services, including pre-admission testing	\$50 per Encounter	Not Covered
Radiology Services, including Ultrasound	\$100 per Encounter	Not Covered
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$200 per Encounter	Not Covered
Ancillary Services	40%	Not Covered



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<b>Prescription Drugs</b>		
<b>Retail Pharmacy</b>		
<b>Tier</b>	<b>In Network</b>	<b>Out of Network</b>
Preventive Medications	\$0	Not Covered
Preferred Generics	\$0/\$30	Not Covered
Preferred Brand and Non-Preferred Generics	\$150	Not Covered
Non-Preferred Brand and Non-Preferred Generics	\$250	Not Covered
Specialty Medications	40%	Not Covered
<b>Mail Order</b>		
<b>Tier</b>	<b>In Network</b>	<b>Out of Network</b>
Preventive Medications	\$0	Not Covered
Preferred Generics	\$0/\$75	Not Covered
Preferred Brand and Non-Preferred Generics	\$375	Not Covered
Non-Preferred Brand and Non-Preferred Generics	\$625	Not Covered
Specialty Medications	40%	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>	20%	Not Covered
Internally Implanted Prosthetic Devices <i>Services require Prior Authorization.</i>	40%	Not Covered
All other Prosthetic Devices <i>Services require Prior Authorization.</i>	40%	Not Covered





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Benefit	In Network	Non Network
Wigs <i>Limited to 1 Item per Calendar Year up to \$500.</i>	\$0	Not Covered

Benefit	In Network	Non Network
<b>Sleep Studies</b>		
Sleep Studies <i>Services require Prior Authorization.</i>	40%	Not Covered

Benefit	In Network	Non Network
<b>Telehealth Virtual Care Services</b>		
Primary Care Telehealth Services	\$30 per Visit	Not Covered
Behavioral Health Telehealth Services	\$0 per Visit	Not Covered
Urgent Care Telehealth Services	\$50 per Visit	\$50 per Visit

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	\$200 per Visit	\$200 per Visit
Anesthesia	\$200 per Visit	\$200 per Visit
Laboratory Services	\$50 per Encounter	\$50 per Encounter
Radiology Services	\$100 per Encounter	\$100 per Encounter
High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging	\$200 per Encounter	\$200 per Encounter
Urgent Care Ancillary Charges	\$200 per Encounter	\$200 per Encounter