Schedule of Benefits
SHA Silver 6700
(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	$6,700/Individual; $13,400/Family	Not Covered
Out-of-Pocket Maximum: - Per Plan Year	$8,700/Individual; $17,400/Family	Not Covered

Benefit	In Network	Non Network
Allergy Services		
Physician Services	$75 per Visit	Not Covered
Allergy Testing	40% after Deductible	Not Covered
Allergy Serum	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Autism Spectrum Disorder Services		
Outpatient Therapy Services *Services require Prior Authorization.*	40% after Deductible	Not Covered
Autism - Applied Behavioral Analysis *Services require Prior Authorization.*	$400 per Visit	Not Covered

Benefit	In Network	Non Network
Chemotherapy & Radiation Treatment		
Chemotherapy Treatment *Services require Prior Authorization.*	40% after Deductible	Not Covered
Radiation Treatment *Services require Prior Authorization.*	40% after Deductible	Not Covered

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

Benefit	In Network	Non Network
Dialysis Services		
Dialysis Treatment *Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Durable Medical Equipment		
Durable Medical Equipment and Devices *Services require Prior Authorization.*	40% after Deductible	Not Covered
Diabetic Shoes *Services require Prior Authorization.*	40% after Deductible	Not Covered
Ostomy Supplies *Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Equipment for the treatment of Positional Plagiocephaly *Services require Prior Authorization.*	40% after Deductible	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	40% after Deductible	40% after Deductible
Emergency Room Physician/ Surgeon charges	$400 per Admission	$400 per Admission
Professional Fees	$400 per Admission	$400 per Admission
Anesthesia	$400 per Encounter	$400 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	40% after Deductible	40% after Deductible
Emergency Room Ancillary Charges	$400 per Encounter	$400 per Encounter
Emergency Ambulance Transport (Ground/Air/Water)	40% after Deductible	40% after Deductible

Benefit	In Network	Non Network
Genetic Testing and Counseling		
Genetic Testing and Counseling *Services require Prior Authorization.*	40% after Deductible	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
Hearing Exam/Evaluation	$75 per Visit	Not Covered
Hearing Aids *Limited to 1 Item(s) per Benefit Period. Benefit period is 5 years. Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Home Health Care		
Home Health *Limited to 28 Hours per Week. Limit combined with Private Duty Nursing. Services require Prior Authorization.*	40% after Deductible	Not Covered
Home Infusion Therapy	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Hospice Care Services		
Hospice Care	40% after Deductible	Not Covered
Bereavement Support Services	$0 per Visit	Not Covered

Benefit	In Network	Non Network
Hospital Services & Inpatient Surgery, including Organ & Tissue Transplants, and Gender Dysphoria and Gender Transition Services *All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.*		
Inpatient Hospital Facility/Surgery *Services require Prior Authorization.*	40% after Deductible	Not Covered
Inpatient Habilitation/ Rehabilitation Facility *Services require Prior Authorization.*	40% after Deductible	Not Covered
Skilled Nursing Facility *Limited to 100 Days per Year. Copay applies per day, up to 2 days.*	40% after Deductible	Not Covered
Professional Fees	40% after Deductible	Not Covered
Surgeon Fees *Services require Prior Authorization.*	40% after Deductible	Not Covered
Anesthesia	40% after Deductible	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	40% after Deductible	Not Covered
Ancillary Services	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Infertility Services		
Diagnosis and Management *Services require Prior Authorization.*	$75 per Visit	Not Covered
Treatment for Infertility	40% after Deductible	Not Covered
Artificial Insemination	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Infusion Therapy		
Infusion Therapy .	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Lab, X-Ray and Diagnostic Services		
Laboratory Services	$50 per Encounter	Not Covered
Radiology Services	$100 per Encounter	Not Covered
High-tech Imaging (MRI, CT, PET Scan), Nuclear Imaging *Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Mental Health and Substance Use Services		
Inpatient Mental Health Care *Services require Prior Authorization.*	40% after Deductible	Not Covered
Outpatient Mental Health Office Visit	$0 per Visit	Not Covered
Inpatient Substance Use Services *Services require Prior Authorization*	40% after Deductible	Not Covered
Outpatient Substance Use Office Visits	$0 per Visit	Not Covered
Other Outpatient Mental Health and Substance Use Services (non-office visits) *Services require Prior Authorization.*	$400 per Visit	Not Covered

Benefit	In Network	Non Network
Outpatient Surgery		
Outpatient Ambulatory Surgery *Services require Prior Authorization.*	$900 per Encounter	Not Covered
Surgeon Fees *Services require Prior Authorization.*	$400 per Encounter	Not Covered
Professional Fees *Services require Prior Authorization.*	$400 per Encounter	Not Covered
Anesthesia	$400 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	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Ancillary Services	$400 per Encounter	Not Covered

Benefit	In Network	Non Network
Outpatient Therapy Services – Rehabilitative and Habilitative		
Rehabilitative Occupational and Rehabilitative Physical Therapy *Limited to 40 Visit(s) per Year. Limited to 20 visits per therapy type per year. Services require Prior Authorization.*	40% after Deductible	Not Covered
Rehabilitative Speech Therapy *Limited to 20 Visit(s) per Year. Services require Prior Authorization.*	40% after Deductible	Not Covered
Cardiac Rehabilitation *Services require Prior Authorization.*	40% after Deductible	Not Covered
Pulmonary Rehabilitation *Services require Prior Authorization.*	40% after Deductible	Not Covered
Inhalation/Respiratory Therapy *Services require Prior Authorization.*	40% after Deductible	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 *Limited to 2 Exam(s) per Year.*	$0 per Visit	Not Covered
Basic Services *See Schedule of Benefits for plan limits. Benefits are available up to the end of the month in which the member turns 19.*	50% after Deductible	Not Covered
Major Services *See Schedule of Benefits for plan limits.*	50% after Deductible	Not Covered
Medically Necessary Orthodontics and Prosthodontics *Medically necessary Orthodontia only. Benefits are available up to the end of the month in which the member turns 19.*	50% after Deductible	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

Benefit	In Network	Non Network
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	$0 per Visit	Not Covered
Specialist Office Visits	No charge for first 2 visit(s) then $75	Not Covered
Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic)	40% after Deductible	Not Covered
Surgeon Fees	$400 per Visit	Not Covered
Anesthesia	$400 per Visit	Not Covered
Injections/Physician Administered Medications (with or without office visit)	40% after Deductible	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 *Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for cesarean delivery require pre-authorization.*	40% after Deductible	Not Covered
Professional Fees	40% after Deductible	Not Covered
Surgeon Fees	40% after Deductible	Not Covered
Anesthesia	40% after Deductible	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	40% after Deductible	Not Covered
Ancillary Services	40% after Deductible	Not Covered

Prescription Drugs		
Retail Pharmacy		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0	Not Covered
Preferred Brand and Non-Preferred Generics	$90	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$150	Not Covered
Specialty Medications	40% after Deductible	Not Covered
Mail Order		
Tier	**In Network**	**Out of Network**
Preventive Medications	$0	Not Covered
Preferred Generics	$0	Not Covered
Preferred Brand and Non-Preferred Generics	$225	Not Covered
Non-Preferred Brand and Non-Preferred Generics	$375	Not Covered
Specialty Medications	40% after Deductible	Not Covered

Benefit	**In Network**	**Non Network**
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.*	20%	Not Covered
Internally Implanted Prosthetic Devices *Services require Prior Authorization.*	40% after Deductible	Not Covered
All other Prosthetic Devices *Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Wigs *Limited to 1 Item per Calendar Year up to $500.*	$0	Not Covered

Benefit	In Network	Non Network
Sleep Studies		
Sleep Studies *Services require Prior Authorization.*	40% after Deductible	Not Covered

Benefit	In Network	Non Network
Telehealth Virtual Care Services		
Primary Care Telehealth Services	$0 per Visit	Not Covered
Behavioral Health Telehealth Services	$0 per Visit	Not Covered
Urgent Care Telehealth Services	$50 per Visit	$50 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.

Benefit	In Network	Non Network
Urgent Care Services		
Urgent Care Facility Fee	$50 per Visit	$50 per Visit
Surgeon Fees	$400 per Visit	$400 per Visit
Anesthesia	$400 per Visit	$400 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	40% after Deductible	40% after Deductible
Urgent Care Ancillary Charges	$400 per Encounter	$400 per Encounter