Schedule of Benefits
Bronze 60 HMO Plan
(Who Pays What)
From 01/01/2022 through 12/31/2022

THIS SCHEDULE OF BENEFITS IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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.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
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 HealthCare 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.

Eligible American Indians/Alaska Natives are exempt from Cost-Sharing requirements when Covered Health Services are received from an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

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General Cost Share & Features	In Network	Non Network
Deductible: - Per Plan Year Medical Pharmacy Dental *Some services do not apply to the deductible, as indicated below.*	$6,300/Individual; $12,600 Family $500 Individual; $1,000 Family $0 Individual; $0 Family	Not covered
Out-of-Pocket Maximum: - Per Plan Year	$8,200/Individual; $16,400 Family	Not covered

Benefit	In Network	Non Network
Health care provider's office or clinic visit		
Primary care visit to treat an injury, illness, or condition	$65; Deductible applies after 1st 3 non-preventive visits	Not covered
Other practitioner office visit	$65; Deductible applies after 1st 3 non-preventive visits	Not covered
Specialist visit	$95; Deductible applies after 1st 3 non-preventive visits	Not covered
Preventive care/screening/ immunization	No charge	Not covered

Benefit	In Network	Non Network
Tests		
Laboratory Tests	$40	Not covered
X-rays and Diagnostic Imaging	40% after deductible	Not covered
Imaging (CT/PET scans, MRIs) *Services require pre-authorization.*	40% after deductible	Not covered

Benefit	In Network Retail Pharmacy	Non Network Retail Pharmacy
Drugs to treat illness or condition *The copay or co-insurance applies to an up to 30-day prescription supply. The enrollee's cost share will be the lower of the pharmacy's retail price, or the applicable cost-share amount. Amounts paid by the enrollee will apply to the Deductible and Out-of-Pocket Maximum.*		
Tier 1	$18; Pharmacy deductible applies	Not covered
Tier 2	40% up to $500 per script after pharmacy deductible	Not covered
Tier 3	40% up to $500 per script after pharmacy deductible	Not covered
Tier 4	40% up to $500 per script after pharmacy deductible	Not covered

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Benefit	In Network	Non Network
Outpatient services		
Surgery facility fee *Services require pre-authorization.*	40% after deductible	Not covered
Physician/surgeon fees *Services require pre-authorization.*	40% after deductible	Not covered
Outpatient visit	40% after deductible	Not covered

Benefit	In Network	Non Network
Need immediate attention		
Emergency room facility fee (waived if admitted)	40% after deductible	40% after deductible
Emergency room physician fee (waived if admitted)	No charge	No charge
Medical transportation (including emergency and non-emergency)	40% after deductible	40% after deductible
Urgent care	$65; Deductible applies after 1st 3 non-preventive visits	$65; Deductible applies after 1st 3 non-preventive visits

Benefit	In Network	Non Network
Hospital stay		
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) *Services require pre-authorization.*	40% after deductible	Not covered
Physician/surgeon fee *Services require pre-authorization.*	40% after deductible	Not covered

Benefit	In Network	Non Network
Mental Health and Substance Abuse Services		
Mental/behavioral health and substance use disorder outpatient office visits	$65	Not covered
Mental/behavioral health and substance use disorder other outpatient items and services	$65	Not covered

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Benefit	In Network	Non Network
Pregnancy		
Prenatal care and preconception visits	No charge	Not covered

Benefit	In Network	Non Network
Help recovering or other special health needs		
Home health care (cost share per visit)	40% after deductible	Not covered
Outpatient Rehabilitation and Habilitation services *Services require pre-authorization.*	$65	Not covered
Skilled nursing care *Services require pre-authorization.*	40% after deductible	Not covered
Durable medical equipment *Services require pre-authorization.*	40% after deductible	Not covered
Hospice service *Services require pre-authorization.*	No charge	Not covered

Benefit	In Network	Non Network
Child eye care – Coverage is available through the end of the month in which the dependent child turns 19.		
Eye Exam with Dilation, as necessary - *Limited to 1 refractive eye exam per calendar year*		
	No charge	Not covered
Eyeglasses - *1 pair of glasses per year (or a 1-year supply of contact lenses in lieu of glasses)*		
Includes single vision, conventional (lined) bifocal, conventional (lined) trifocal, lenticular, and standard progressive lenses. Frames are covered in full when provider designated frames are selected.	No charge	Not covered
Contact Lenses for Refraction (in lieu of contact lenses)		
Includes: • Extended wear disposables • Daily wear / disposables • Conventional • Medically Necessary contact lenses.	No charge	Not covered
Low Vision Services		
Exam	No charge	No charge

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Benefit	In Network	Non Network
Low vision aids	25% copay up to $1,000 every 24 months	25% copay up to $1,000 every 24 months

Benefit	In Network	Non Network
Child Dental Diagnostic and Preventive		
Oral Exam	No charge	Not covered
Preventive - Cleaning	No charge	Not covered
Preventive - X-ray	No charge	Not covered
Sealants per Tooth	No charge	Not covered
Topical Fluoride Application	No charge	Not covered
Space Maintainers - Fixed	No charge	Not covered

Benefit	In Network	Non Network
Child Dental Basic Services		
Restorative Procedures	20%	Not covered
Periodontal Maintenance Services	20%	Not covered

Benefit	In Network	Non Network
Child Dental Major Services		
Crowns and Casts	50%	Not covered
Endodontics	50%	Not covered
Periodontics (other than maintenance)	50%	Not covered
Prosthodontics	50%	Not covered
Oral Surgery	50%	Not covered

Benefit	In Network	Non Network
Child Orthodontics		
Medically necessary orthodontics	50%	Not covered

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

1. Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-Network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2. For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4. For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5. For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 202 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6. Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7. For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
8. Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
9. In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10. For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11. As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
12. A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2022 Dental Copay Schedule.
13. Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14. Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient- Centered Benefit Plan Designs.
15. Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16. Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17. Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18. The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable

benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

19. The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
20. The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
21. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
22. Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23. Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low-cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Some drugs may be subject to zero cost-sharing under the preventive services rules.

24. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
25. A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
26. The health issuer may not impose a member cost share for Diabetes Self- Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27. The cost sharing for hospice services applies regardless of the place of service.
28. For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.

29. For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
30. For any benefit plan design in which a designation of Individual-Only or CCSB- Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
31. The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.