



**Schedule of Benefits  
Silver 4000 HSA  
(Who Pays What)  
From 01/01/2023 through 12/31/2023**

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 [brighthouse.com](http://brighthouse.com) or You can contact Bright HealthCare Member Services at (844) 926-4524 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 Percentage Copayment, 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. Copayment charges for the calendar year will not exceed 200 percent of the total annual premium cost.

**Percentage Copayment**

Percentage Copayment is the percentage of any Allowed Amount that You are required to pay for certain Covered Health Services. Percentage Copayment amounts accumulate towards Your Out-of-Pocket Maximum. Percentage Copayment charges will not exceed 50 percent of the total cost of services provided.

**Out-of-Pocket Maximum**

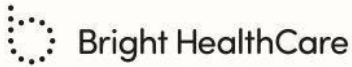
The Out-of-Pocket Maximum is the maximum amount of Deductible, Percentage Copayment, or Copayments You pay in a calendar year. All Deductible, Copayment and Percentage Copayment payments for In-Network Covered Health Services will apply to the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a Covered Person, the Covered Person will have no further obligation to pay Deductible, Copayment or Percentage Copayment 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>Annual Deductible:</b><br>Per Plan Year<br>- Medical | \$4,000/Individual;<br>\$8,000/Family  | Not Covered        |
| <b>Out-of-Pocket Maximum:</b><br>Per Plan Year          | \$7,500/Individual;<br>\$15,000/Family | Not Covered        |



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| Benefit                 | In Network                      | Non Network |
|-------------------------|---------------------------------|-------------|
| <b>Allergy Services</b> |                                 |             |
| Physician Services      | \$60 per Visit after Deductible | Not Covered |
| Allergy Testing         | 20% after Deductible            | Not Covered |
| Allergy Serum           | 20% after Deductible            | Not Covered |

| Benefit  | In Network           | Non Network |
|--|----------------------|-------------|
| <b>Autism Spectrum Disorder Services</b>   |                      |             |
| Outpatient Therapy Services<br><i>Services require Prior Authorization.</i>          | 20% after Deductible | Not Covered |
| Autism - Applied Behavioral Analysis<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |

| Benefit  | In Network           | Non Network |
|--|----------------------|-------------|
| <b>Chemotherapy &amp; Radiation Treatment</b>                          |                      |             |
| Chemotherapy Treatment<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |
| Radiation Treatment<br><i>Services require Prior Authorization.</i>    | 20% after Deductible | Not Covered |

| Benefit   | In Network                      | Non Network |
|---|---------------------------------|-------------|
| <b>Chiropractic Care</b>  |                                 |             |
| Spinal Manipulations<br><i>Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share.</i> | \$35 per Visit after Deductible | Not Covered |
| Diagnostic X-ray Services   | 20% after Deductible            | Not Covered |

| Benefit                        | In Network                      | Non Network |
|--------------------------------|---------------------------------|-------------|
| <b>Convenience Care</b>        |                                 |             |
| Convenience Care Clinic visit  | \$25 per Visit after Deductible | Not Covered |
| Diagnostic Laboratory Services | 20% after Deductible            | Not Covered |

| Benefit            | In Network | Non Network |
|--------------------|------------|-------------|
| <b>Dental Care</b> |            |             |



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| <b>Adult Dental Services</b>  |                  |             |
|---|------------------|-------------|
| Diagnostic and Preventive Services  | Not Covered      | Not Covered |
| Basic Dental Care   | Not Covered      | Not Covered |
| Major Dental Care   | Not Covered      | Not Covered |
| Orthodontia   | Not Covered      | Not Covered |
| <b>Pediatric Dental Services for Dependent Children (through the end of the month in which they turn age 19)</b>                      |                  |             |
| Diagnostic and Preventive Services<br><i>Limited to 2 Exam(s) per Year.</i>   | \$0 per Visit    | Not Covered |
| Basic Dental Care<br><i>Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.</i>                                   | \$50 per Visit   | Not Covered |
| Major Dental Care<br><i>Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.</i>                                   | \$690 per Visit  | Not Covered |
| Medically Necessary Orthodontics and Prosthodontics<br><i>Limitations apply. Refer to Your Pediatric Dental Schedule of Benefits.</i> | \$2800 per Visit | Not Covered |

| <b>Benefit</b>   | <b>In Network</b>    | <b>Non Network</b> |
|--|----------------------|--------------------|
| <b>Dialysis Services</b>   |                      |                    |
| Dialysis Treatment<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered        |

| <b>Benefit</b>   | <b>In Network</b>    | <b>Non Network</b> |
|--|----------------------|--------------------|
| <b>Durable Medical Equipment</b>   |                      |                    |
| Durable Medical Equipment and Devices<br><i>Services require Prior Authorization.</i>  | 20% after Deductible | Not Covered        |
| Diabetic Shoes<br><i>Services require Prior Authorization. Limited to 1 Item(s) per Year.</i>                                      | 20% after Deductible | Not Covered        |
| Ostomy Supplies<br><i>Services require Prior Authorization.</i>  | 20% after Deductible | Not Covered        |
| Equipment for the treatment of Positional Plagiocephaly<br><i>Services require Prior Authorization. Limited to 1 per lifetime.</i> | 20% after Deductible | Not Covered        |

| <b>Benefit</b>   | <b>In Network</b> | <b>Non Network</b> |
|--|-------------------|--------------------|
| <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> |                   |                    |



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|  |                      |                      |
|--|----------------------|----------------------|
| Emergency Room Facility                                | 20% after Deductible | 20% after Deductible |
| Emergency Room Physician                               | 20% after Deductible | 20% after Deductible |
| Emergency Room Surgeon                                 | 20% after Deductible | 20% after Deductible |
| Emergency Room Anesthesiologist                        | 20% after Deductible | 20% after Deductible |
| Laboratory Services                                    | 20% after Deductible | 20% after Deductible |
| Radiology Services                                     | 20% after Deductible | 20% after Deductible |
| High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging | 20% after Deductible | 20% after Deductible |
| Emergency Room Ancillary Services                      | 20% after Deductible | 20% after Deductible |
| Emergency Ambulance Transport (Ground/Air/Water)       | 20% after Deductible | 20% after Deductible |

| Benefit  | In Network           | Non Network |
|--|----------------------|-------------|
| <b>Genetic Testing and Counseling</b>  |                      |             |
| Genetic Testing and Counseling<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |

| Benefit  | In Network                      | Non Network |
|--|---------------------------------|-------------|
| <b>Hearing Services</b>  |                                 |             |
| Hearing Screening<br><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  | \$60 per Visit after Deductible | Not Covered |
| Hearing Aids<br><i>Limited to 1 Item(s) per 3 years.</i>   | 20% after Deductible            | Not Covered |

| Benefit  | In Network           | Non Network |
|--|----------------------|-------------|
| <b>Home Health Care</b>  |                      |             |
| Home Health<br><i>Services require Prior Authorization. Limited to 60 Visit(s) per Year.</i> | 20% after Deductible | Not Covered |
| Home Infusion Therapy  | 20% after Deductible | Not Covered |

| Benefit                      | In Network                     | Non Network |
|------------------------------|--------------------------------|-------------|
| <b>Hospice Care Services</b> |                                |             |
| Hospice Care                 | 20% after Deductible           | Not Covered |
| Bereavement Support Services | \$0 per Visit after Deductible | Not Covered |



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| <b>Hospital Services &amp; Inpatient Surgery, including Organ &amp; Tissue Transplants</b><br><i>All transplants must be performed at a plan-designated Centers of Excellence Facility or transplant center.</i> |                      |             |
| Inpatient Hospital Facility/Surgery<br><i>Services require Prior Authorization.</i>  | 20% after Deductible | Not Covered |
| Inpatient Habilitation/<br>Rehabilitation Facility<br><i>Services require Prior Authorization.</i>   | 20% after Deductible | Not Covered |
| Skilled Nursing Facility<br><i>Services require Prior Authorization.</i><br><i>Limited to 25 Visit(s) per Year.</i>  | 20% after Deductible | Not Covered |
| Professional Fees<br><i>Services require Prior Authorization.</i>  | 20% after Deductible | Not Covered |
| Surgeon Fees<br><i>Services require Prior Authorization.</i>   | 20% after Deductible | Not Covered |
| Anesthesia   | 20% after Deductible | Not Covered |
| Laboratory Services, including<br>pre-admission testing  | 20% after Deductible | Not Covered |
| Radiology Services   | 20% after Deductible | Not Covered |
| High-Tech Imaging (MRI, CT,<br>PET Scan), Nuclear Imaging  | 20% after Deductible | Not Covered |
| Ancillary Services   | 20% after Deductible | Not Covered |

| Benefit  | In Network                      | Non Network |
|--|---------------------------------|-------------|
| <b>Infertility Services</b>  |                                 |             |
| Diagnosis and Management<br><i>Services require Prior Authorization.</i> | \$60 per Visit after Deductible | Not Covered |
| Treatment for Infertility  | Not Covered                     | Not Covered |
| Artificial Insemination  | Not Covered                     | Not Covered |

| Benefit                 | In Network           | Non Network |
|-------------------------|----------------------|-------------|
| <b>Infusion Therapy</b> |                      |             |
| Infusion Therapy        | 20% after Deductible | Not Covered |

| Benefit   | In Network           | Non Network |
|---|----------------------|-------------|
| <b>Lab, X-Ray and Diagnostic Services</b>   |                      |             |
| Laboratory Services   | 20% after Deductible | Not Covered |
| Radiology Services  | 20% after Deductible | Not Covered |
| High-tech Imaging (MRI, CT, PET<br>Scan), Nuclear Imaging<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |



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| <b>Mental Health and Substance Use Services</b>  |                                |             |
| Bright HealthCare maintains compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) as well as any additional state parity requirements. Bright HealthCare will not impose more restrictive financial requirements or treatment limitations to mental health or substance use benefits than those on medical/surgical benefits. |                                |             |
| Inpatient Mental Health Care<br><i>Services require Prior Authorization.</i>   | 20% after Deductible           | Not Covered |
| Outpatient Mental Health Office Visit  | \$0 per Visit after Deductible | Not Covered |
| Mental Health Telehealth Services  | \$0 per Visit after Deductible | Not Covered |
| Bright Health Telehealth Services  | \$0 per Visit after Deductible | Not Covered |
| Inpatient Substance Use Services<br><i>Services require Prior Authorization.</i>   | 20% after Deductible           | Not Covered |
| Outpatient Substance Use Office Visits   | \$0 per Visit after Deductible | Not Covered |
| Other Outpatient Mental Health and Substance Use Services (non-office visits)<br><i>Services require Prior Authorization.</i>  | 20% after Deductible           | Not Covered |

| Benefit   | In Network           | Non Network |
|---|----------------------|-------------|
| <b>Outpatient Surgery</b>   |                      |             |
| Outpatient Ambulatory Surgery<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |
| Surgeon Fees<br><i>Services require Prior Authorization.</i>                  | 20% after Deductible | Not Covered |
| Professional Fees<br><i>Services require Prior Authorization.</i>             | 20% after Deductible | Not Covered |
| Anesthesia  | 20% after Deductible | Not Covered |
| Laboratory Services, including pre-admission testing                          | 20% after Deductible | Not Covered |
| Radiology Services  | 20% after Deductible | Not Covered |
| High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging                        | 20% after Deductible | Not Covered |
| Ancillary Services  | 20% after Deductible | Not Covered |

| Benefit  | In Network | Non Network |
|--|------------|-------------|
| <b>Outpatient Therapy Services – Rehabilitative and Habilitative</b> |            |             |



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| Rehabilitative Occupational and Rehabilitative Physical Therapy Services require Prior Authorization. Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share. | 20% after Deductible | Not Covered |
| Rehabilitative Speech Therapy Services require Prior Authorization. Limited to 35 Visit(s) per Year. Visits combined for Physical, Occupational and Speech Therapy and Chiropractic spinal manipulations. Habilitation services includes autism services. Visit limit does not apply for services related to mental health. For mental health related services, see Mental Health Outpatient Services for the applicable cost share.                                   | 20% after Deductible | Not Covered |
| Cardiac Rehabilitation Services require Prior Authorization.   | 20% after Deductible | Not Covered |
| Pulmonary Rehabilitation Services require Prior Authorization.   | 20% after Deductible | Not Covered |
| Inhalation/Respiratory Therapy Services require Prior Authorization.   | 20% after Deductible | Not Covered |

| Benefit   | In Network                        | Non Network |
|---|-----------------------------------|-------------|
| <b>Physician's Office Services</b>  |                                   |             |
| Primary Care Office Visits  | \$35 per Visit after Deductible   | Not Covered |
| Primary Care Telehealth   | Same as Primary Care Office Visit | Not Covered |
| Bright Health Telehealth Services   | No charge                         | Not Covered |
| Specialist Office Visits  | \$60 per Visit after Deductible   | Not Covered |
| Clinic Fees for Office Visits at an Outpatient Clinic (hospital-owned clinic) | \$35 per Visit after Deductible   | Not Covered |
| Surgeon Fees  | 20% after Deductible              | Not Covered |
| Anesthesia  | 20% after Deductible              | Not Covered |
| Injections/Physician Administered Medications (with or without office visit)  | \$35 per Visit after Deductible   | Not Covered |

| Benefit | In Network | Non Network |
|---------|------------|-------------|
|---------|------------|-------------|



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| <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   | \$35 per Visit after Deductible | Not Covered |
| Delivery Facility Fee   | 20% after Deductible            | Not Covered |
| Professional Fees   | 20% after Deductible            | Not Covered |
| Surgeon Fees  | 20% after Deductible            | Not Covered |
| Anesthesia  | 20% after Deductible            | Not Covered |
| Laboratory Services, including pre-admission testing  | 20% after Deductible            | Not Covered |
| Radiology Services, including Ultrasound  | 20% after Deductible            | Not Covered |
| High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging  | 20% after Deductible            | Not Covered |
| Ancillary Services  | 20% after Deductible            | Not Covered |

| <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 after Deductible/\$20 after Deductible | Not Covered           |
| Preferred Brand and Non-Preferred Generics     | 20% after Deductible                       | Not Covered           |
| Non-Preferred Brand and Non-Preferred Generics | 20% after Deductible                       | Not Covered           |
| Specialty Medications                          | 20% after Deductible                       | 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 after Deductible/\$50 after Deductible | Not Covered           |
| Preferred Brand and Non-Preferred Generics     | 20% after Deductible                       | Not Covered           |
| Non-Preferred Brand and Non-Preferred Generics | 20% after Deductible                       | Not Covered           |
| Specialty Medications                          | 20% after Deductible                       | Not Covered           |

| <b>Benefit</b>                          | <b>In Network</b> | <b>Non Network</b> |
|---|-------------------|--------------------|
| <b>Preventive and Wellness Services</b> |                   |                    |





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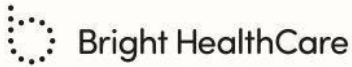
|   |               |             |
|---|---------------|-------------|
| Preventive Care Services, Screenings and Immunizations  | \$0 per Visit | Not Covered |
| Breast Cancer and Mammography Screening   | \$0 per Visit | Not Covered |
| <p>Visit <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations">https://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.</p> |               |             |

| Benefit  | In Network           | Non Network |
|--|----------------------|-------------|
| <b>Prosthetics</b>   |                      |             |
| Prosthetic Limbs<br><i>Services require Prior Authorization.</i>   | 20% after Deductible | Not Covered |
| Internally Implanted Prosthetic Devices<br><i>Services require Prior Authorization.</i>  | 20% after Deductible | Not Covered |
| All other Prosthetic Devices<br><i>Services require Prior Authorization.</i>   | 20% after Deductible | Not Covered |
| Wigs<br><i>Limited to 1 Item(s) per Year for covered persons undergoing treatment for cancer or other conditions treated by chemotherapy or radiation.</i> | \$0                  | Not Covered |

| Benefit   | In Network           | Non Network |
|---|----------------------|-------------|
| <b>Sleep Studies</b>  |                      |             |
| Sleep Studies<br><i>Services require Prior Authorization.</i> | 20% after Deductible | Not Covered |

| 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    | \$60 per Visit after Deductible | \$60 per Visit after Deductible |
| Surgeon Fees                | 20% after Deductible            | 20% after Deductible            |
| Anesthesia                  | 20% after Deductible            | 20% after Deductible            |



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| Laboratory Services                                    | 20% after Deductible | 20% after Deductible |
| Radiology Services                                     | 20% after Deductible | 20% after Deductible |
| High-Tech Imaging (MRI, CT, PET Scan), Nuclear Imaging | 20% after Deductible | 20% after Deductible |
| Urgent Care Ancillary Services                         | 20% after Deductible | 20% after Deductible |

| Benefit   | In Network          | Non Network |
|---|---------------------|-------------|
| <b>Vision Services</b>  |                     |             |
| <b>Adult Vision Services</b>  |                     |             |
| Routine Eye Exam  | Not Covered         | Not Covered |
| Eyeglasses  | Not Covered         | Not Covered |
| Contact Lenses  | Not Covered         | Not Covered |
| <b>Pediatric Vision Services for Dependent Children (through the end of the month in which they turn age 19)</b>  |                     |             |
| Routine Eye Exam<br><i>Limited to 1 Exam(s) per Year.</i>   | \$0 per Visit       | Not Covered |
| Eyeglasses<br><i>Limited 1 pair of eyeglasses per year in lieu of contact lenses. Refer to Your Pediatric Vision Schedule of Benefits for more information.</i> | 0% after Deductible | Not Covered |
| Contact Lenses<br><i>Limited a supply of contact lenses in lieu of eyeglasses. Refer to Your Pediatric Vision Schedule of Benefits for more information.</i>    | 0% after Deductible | Not Covered |
| Low Vision Exam   | Not Covered         | Not Covered |
| Low Vision Aids   | Not Covered         | Not Covered |