The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 954-622-3499. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 954-622-3499 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual Family In-network: **$100** **$300**	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	Yes. Preventive Services and Pharmacy	This plan covers some items and services even if you haven't yet met the annual **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive** services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** for employee only / **$8,000** for employee plus spouse, employee plus child(ren), employee plus family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums** and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes- The Memorial Health Network (MHN). For a list of **preferred providers**, see the Lawson website, email CCP.CustomerSvc@ccpcares.org,or **call 954-622-3499**	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays **(balance billing)**. Be aware, your network provider might use an out-of-network **provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit after deductible	Not Covered	None
	Specialist visit	$30 copay / visit after deductible	Not Covered	Chiropractor: $40 copay/visit (60 visit maximum) – 20% after deductible for infertility services - 1 Progyny Smart Cycle
	Preventive care/screening/ Immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay after deductible	Not Covered	No Charge for Labs.
	Imaging (CT/PET scans, MRIs)	$100 copay / test after deductible	Not Covered	MRI, CT/PET scans require prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from **Southern Scripts** at 1-800-710-9341 or southernscripts.net	Generic drugs	$10 copay / 30 day **retail** supply, $20 copay **90 day retail** supply*, $20 copay / 90 day **mail-order** supply	Not Covered	In-house Pharmacy $10 copay / 30 day supply $20 copay / 90 day supply *One copay per month (3 copays) will apply for 90 day retail prescriptions outside of the First Choice network
	Preferred brand drugs	$35 copay / 30 day **retail** supply, $70 copay **90 day retail** supply*, $70 copay / 90 day **mail-order** supply	Not Covered	In-house Pharmacy $20 copay / 30 day supply $55 copay / 90 day supply *One copay per month (3 copays) will apply for 90 day retail prescriptions outside of the First Choice network

* For more information about limitations and exceptions, call 954 622 3499.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	40% ($50 minimum, $150 maximum) / 30 day **retail** prescription, 40% ($150 minimum, $210 maximum **90 day retail supply***, 40% ($70 minimum, $210 maximum) / 90 day **mail-order** supply	Not Covered	In-house Pharmacy 40% ($35 min, $135 max) / 30 day supply 40% ($55 min $195 max) / 90 day supply * The coinsurance maximum applies per 30 day supply for 90 day retail prescriptions outside of the First Choice network In the event a Tier 1 equivalent medication is available the member will be responsible for a co-pay of 40% (a minimum $50 and a maximum of $150) plus the cost difference between the Tier 1 equivalent and the Tier 3 medication.
	Specialty drugs	40% ($150 minimum $300 maximum)	Not Covered	Only covered at MHS pharmacies and the CRx Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay after deductible	Not Covered, except in an emergency	Some services may require prior authorization. – 20% after deductible for infertility services which include 1 Progyny Smart Cycle. An additional cycle is available when a successful pregnancy is not achieved.
	Physician/surgeon fees	$0 copay after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$150 copay / visit, waived if admitted after deductible	$150 copay / visit, waived if admitted after deductible	None
	Emergency medical transportation	$50 copay / event after deductible	$50 copay / event after deductible	Non-emergency transportation requires prior authorization
	Urgent care • CVS Minute Clinic/ Walgreens • Memorial Primary Care	$20 copay / visit after deductible $20 copay / visit after deductible	$75 (Non-Memorial Urgent Care Center) after deductible	None

* For more information about limitations and exceptions, call 954 622 3499.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	• Holy Cross Urgent Care Centers • MHS Urgent Care Centers • PM Pediatrics • Memorial Pembroke 24/7 Care Center (Douglas Rd) • MDNOW Urgent Care • Selected Broward Health locations	$20 copay / visit after deductible $20 copay / visit after deductible $20 copay / visit after deductible $20 copay / visit after deductible $75 copay / visit after deductible $75 copay / visit after deductible		
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay per day (5 day max) after deductible	Not Covered, unless admitted through an emergency room	5 day max. Requires Prior Authorization
	Physician/surgeon fees	$0 copay after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / per visit after deductible	Not Covered	None
	Inpatient services	$150 copay per day (5 day max) after deductible	Not Covered	Copay applicable to first 5 days of each admission. Requires Prior Authorization
If you are pregnant	Office visits	$150 physician copay / pregnancy after deductible	Not Covered	No prior authorization required for initial visit, but is required thereafter.
	Childbirth/delivery professional services	$0 copay after deductible	Not Covered	None
	Childbirth/delivery facility services	$0 copay after deductible	Not Covered	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	$15 copay / day after deductible	Not Covered	Requires prior authorization. Limited to 60 visits per calendar year.
	Rehabilitation services	$20 per day after deductible	Not Covered	Physical therapy, occupational therapy and speech therapy visits are limited to sixty (60)

* For more information about limitations and exceptions, call 954 622 3499.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Cardiac Rehabilitation covered in Full		visits per calendar year. Cardiac rehabilitation is limited to 36 visits per episode.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	$0 copay after deductible	Not Covered	Requires Prior Authorization; limited to 45 days per calendar year.
	Durable medical equipment	$0 copay after deductible	Not Covered	Some services may require prior authorization. Subject to medical necessity review
	Hospice services	$0 copay after deductible	Not Covered	Requires prior authorization; limited to a maximum benefit of $10,000. Limited to life expectancy of less than six months.
If your child needs dental or eye care	Children's eye exam	$0 copay after deductible	Not Covered	Limited to one exam per calendar year for covered children as a preventive service. A separate vision plan is available.
	Children's glasses	Not Covered	Not Covered	Not covered under the medical plan. A separate vision plan is available.
	Children's dental check-up	Not Covered	Not Covered	Not covered under the medical plan. A separate dental plan is available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Appeals Coordinator, c/o Community Care Plan 1643 Harrison Parkway, Suite 200, Bldg. H. Sunrise, Florida 33323.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 954 622 3499.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, call 954 622 3499.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$100**
- **Specialist *copay*** **$30**
- **Hospital (facility) *copay*** **$0 for maternity**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$100**
- **Specialist *copay*** **$30**
- **Hospital (facility) *copay*** **$150 per day (5 day max)**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$100**
- **Specialist *copay*** **$30**
- **Hospital (facility) *copay*** **$150 per day (5 day max)**
- **Other *coinsurance*** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

The plan would be responsible for the other costs of these EXAMPLE covered services.