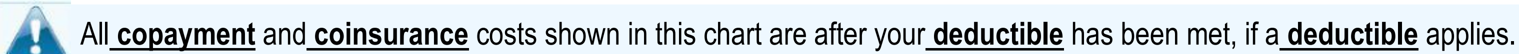
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (954) 622-3400. 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 https://www.healthcare.gov/sbc-glossary or call (954) 622-3400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Individual **$2,000** Family	See the Common Medical Events Chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes**	This plan covers some items and services even if you haven't yet met the deductible. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You don't have to meet a deductible for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$3,500** for individual **$7,000** for family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premium, balance billing 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. Community Care Plan Network (CCP). Email: Member.Services@ccpcares.org or call (954) 622-3400 for a list of network providers	This plan uses a provider network. If you use an in-network doctor or other health care provider, this plan will pay some or all of the cost of covered services. Services provided out of network are not covered except in the event of an emergency. Plans use the term in-network, preferred provider, or participating provider in their Network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No	You can see the in-network 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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	None
	Specialist visit	$40 copay/visit	Not covered	None
	Other practitioner of visit (e.g., chiropractor)	$40 copay/visit	covered	Prior authorization required after initial visit. 60-visit maximum
	Preventive care/screening/ immunization	$0	Not covered	In accordance with federal guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (Lab work)	$0	Not covered	None
	X-ray & Ultrasound Services	$50 copay	Not covered	Excludes OB related ultrasounds
	Advanced Imaging (CT/PET/SPECT/MRI)	$125 copay/test	Not covered	PET/SPECT scans require prior authorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.southernscripts.net Mail Order through Postal Prescription: www.southernscripts.net Specialty Rx through CRx Specialty Solution Pharmacy: www.southernscripts.net **Southern Scripts Customer Care Specialist:** (800) 710-9341	Generic	**First Choice: 30-day retail** supply: $10 copay; **31-60-day retail** supply: $20 copay; **90-day mail order** supply: $10 copay.	Not covered	Southern Scripts retail **First Choice Preferred network** includes **Publix, CVS and Walmart**.
	Formulary Brand	**First Choice Network Provider: 30-day retail** supply: $40 copay; **31-60-day retail** supply: $80 copay; **90-day mail order** supply: $40 copay.	Not covered	Southern Scripts retail **First Choice Preferred network** includes **Publix, CVS and Walmart**. A participant choosing a brand drug over a generic will pay a coinsurance of 40% (a minimum $60 and maximum of $200) **PLUS** the ancillary fee which is the cost differential between the two drugs.

* For more information about limitations and exceptions, see the plan or policy document at https://portal.brhpc.org

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
	Non-Formulary Brand	**First Choice Network Provider: 30-day retail** supply: 40% (min $60/max $200); **31-60-day retail** supply: 40% (min $100/max $300); **90-day mail order** supply: 40% (min $70/max $210)	Not covered	Southern Scripts retail **First Choice Preferred network** includes **Publix, CVS and Walmart.** A participant choosing a brand drug over a generic will pay a coinsurance of 40% (a minimum $60 and maximum of $200) **PLUS** the ancillary fee which is the cost differential between the two drugs
	Specialty drugs	**30-day** supply: 40% (min $150/max $300)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay after deductible	Not covered	Some services require prior authorization
	Physician/surgeon fees	$0	Not covered	None
If you need immediate medical attention	Emergency room care	$125 copay after deductible; waived if admitted	$125 copay after deductible; waived if admitted	Non-emergency use is not covered
	Emergency medical transportation	$50 copay / event	$50 copay / event	Non-emergency transportation requires prior authorization
	Urgent care	$50 CCP facilities $20 CVS Minute Clinic	$75 Non-CCP facilities	CCP Facilities: Broward Health Urgent Care, Memorial 24/7 Care Center, MD Now Medical Centers; Convenience Care Clinic- CVS Minute Clinic Only
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copay per day/after deductible (5-day max) CCP facilities only. All other facilities $200 copay per day/after deductible (5-day max)	Not covered unless admitted through an emergency room	Requires prior authorization. CCP Network includes Broward Health and Memorial Healthcare System facilities. https://providerdirectory.ccpcares.org/
	Physician/surgeon fees	$0	Not covered	None

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	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / per visit	Not Covered	Prior authorization required
	Inpatient services	$75 copay per day/after deductible (5-day max) CCP facilities only	Not Covered	Copay applicable to first 5 days of each admission. Requires Prior Authorization
If you are pregnant	Office visits	$40 copay; initial visit only	Not Covered	None
	Childbirth/delivery professional services	$150 physician copay/pregnancy	Not Covered	Requires pre-authorization for global OB; Maternity care may include tests and services described elsewhere in the SBC.
	Labor Checks	$50 copay CCP facilities only (waived if admitted)	$75 copay non- CCP facilities (waived if admitted)	None
	Childbirth/delivery facility services	$75 copay per day after deductible (5-day max) CCP facilities only	All non CCP facilities $200 copay per day after deductible (5-day max)	Copay applicable to first 5 days of each admission. Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	$25 copay/day	Not covered	Requires prior authorization. Limited to 60 visits per calendar year.
	Rehabilitation services	$20 copay/day	Not covered	Limited to 60 physical therapy, occupational therapy and speech therapy visits combined per calendar year. Cardiac rehabilitation is limited to 36 visits per episode.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	$0	Not covered	Requires prior authorization; limited to 45 days per calendar year.
	Durable medical equipment	$0	Not covered	Some services may require prior authorization. Subject to medical necessity review
	Hospice services	$0	Not covered	Requires prior authorization; limited to a maximum benefit of $10,000. Limited to life expectancy of less than six months.

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	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Available under separate vision plan
	Children's glasses	Not covered	Not covered	Available under separate vision plan
	Children's dental check-up	Not covered	Not covered	Available under separate dental plan

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
- Infertility treatment (diagnosis only is covered)
- 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
- Chiropractic care

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:

- For more information on your rights to continue coverage, contact the CCP plan at (954) 622-3400 or BRHPC Human Resources at (954) 561-9681.

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 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: the CCP plan at (954) 622-3400 or Human Resources at (954) 561-9681.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-954-622-3400 (TTY: 1-855-655-5303).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-954-622-3400 (TTY: 1-855-655-5303).

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

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** **$1,000**
- **Specialist *[cost sharing]*** **$40**
- **Hospital (facility) *[cost sharing]*** **$75**
- **Other *[cost sharing]*** **$50**

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$2,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,000**
- **Specialist *[cost sharing]*** **$40**
- **Hospital (facility) *[cost sharing]*** **$75**
- **Other *[cost sharing]*** **$50**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	1,000
Copayments	$1,070
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,125**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist *[cost sharing]*** **$40**
- **Hospital (facility) *[cost sharing]*** **$75**
- **Other *[cost sharing]*** **$50**

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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