COMMUNITY CARE PLAN-BCG

Coverage Period: 01/01/2019 – 12/31/2019

Basic Plan and CCP Careguardian Program (CCP)

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 (866) 224-5701. 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.healthcare.gov/sbc-glossary or call (866) 224-5701 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,300** Individual / **$2,600** Family per calendar year. Copays and services listed below as "No Charge" do not apply to the deductible.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay for covered services you use. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
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 annual deductible amount. However, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet a separate deductible for specific services.
What is the out-of-pocket limit for this plan?	**Medical** **$2,800** individual **$5,600** family **Prescription** **$3,000 Individual** **$6,000 Family**	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. This limit helps you plan for health care expenses. A separate out-of-pocket limit applies to the prescription drug plan and is illustrated in the column to the left. Qualifying Conditions for CCP Careguardian Program: 1) Hypertension, 2) Diabetes/Pre-diabetes, 3) Respiratory Conditions/Asthma/COPD, & 4) High Risk Pregnancy
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.**

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Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.ccpcares.org/BCG, email Member.Services@ccpcares.org or call (866) 224-5701	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, that your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers 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 permission from this plan.

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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	$25 copay per visit CCP Careguardian Program: No Copay	Not Covered	Virtual visits (Telehealth) - $40 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50 copay per visit CCP Careguardian Programs: $25.00 copay	Not Covered	If you receive services in addition to office visit, additional coinsurance, deductibles, or copayments may apply.
	Other practitioner office visit (e.g. chiropractor)	20% coinsurance after deductible.	Not Covered	Cost share applies for only manipulative (chiropractic) services and is limited to 24 visits per calendar year.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventative health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, ultrasound, lab work)	Office or Independent Lab: No Charge Outpatient Facility: 20% coinsurance; up to $100; then covered at 100%; deductible does not apply	Not Covered	Excludes OB-related ultrasounds
	Advanced Imaging (CT/PET/SPECT/MRI)	Office: No Charge Outpatient Facility: 20% coinsurance; up to $100; then covered at 100%; deductible does not apply	Not Covered	PET/SPECT scans require prior authorization

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 Southern Scripts: www.southernscripts.net	Generic drugs	30 Day Retail: $7 copay 90 Day Retail and Mail Order: $14 copay	Not Covered	Coverage for prescription drugs with CCP's PBM. Not integrated with overall medical deductible.
	Preferred brand drugs	30 Day Retail: $30 copay 90 Day Retail and Mail Order: $60 copay	Not Covered	Coverage for prescription drugs with CCP's PBM. Not integrated with overall medical deductible.
	Non-preferred brand drugs	30 Day Retail: $50 copay 90 Day Retail and Mail Order: $100 copay	Not Covered	Coverage for prescription drugs with CCP's PBM. Not integrated with overall medical deductible.
	Specialty drugs	Up to a 30 Day Supply: $75 copay	Not Applicable	Coverage for prescription drugs with CCP's Specialty PBM. Not integrated with overall medical deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible.	Not Covered	Some services require prior authorization
	Physician/surgeon fees	20% coinsurance after deductible.	Not Covered	None
If you need immediate medical attention	Emergency room care	$250 copay per visit	$250 copay per visit	Non-emergency use is not covered
	Emergency medical transportation	20% coinsurance after deductible.	*20% co-ins after ded.	Non-emergency transportation requires prior authorization
	Urgent Care Clinic	$50 copay per visit CCP Network only	Not Covered	**CCP Network Urgent Care Facilities**
	Convenient Care Center*	$25 copay per visit		*CVS Minute Clinic only

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible.	Not Covered	Requires prior authorization
	Physician/surgeon fees	20% coinsurance after deductible.		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 20 visits per year: No Charge After 20 visits: $25 copay per visit	Not Covered	Partial hospitalization/intensive outpatient treatment: $25 copay per visit.
	Inpatient services	20% coinsurance after deductible.	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	None
	Childbirth/delivery professional services	20% coinsurance after deductible.	Not Covered	Requires prior authorization for global OB; Maternity care may include tests and services described elsewhere in the SBC.
	Labor Checks	20% coinsurance after deductible.	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance after deductible.	Not Covered	Requires prior authorization
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible.	Not Covered	Limited to 60 visits per calendar year. Requires prior authorization.
	Rehabilitation services	20% coinsurance after deductible.	Not Covered	Limits per calendar year: 60 combined visits for physical, speech, occupational therapies; cardiac – unlimited visits; pulmonary – unlimited visits.
	Habilitation services	20% coinsurance after deductible.	Not Covered	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	20% coinsurance after deductible.	Not Covered	Limited to 60 days per calendar year. (combined with inpatient rehabilitation) Requires prior authorization.
	Durable medical equipment	20% coinsurance after deductible.	Not Covered	Some services require prior authorization

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance after deductible.	Not Covered	Some services require prior authorization
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam every year
	Children's glasses	Not Covered	Not Covered	See Vision service and Discount Benefits
	Children's dental check-up	No Charge	Not Covered	Limited to 1 exam every year

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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Annual Vision Evaluation (Adult/Child)
- Hearing Aids – limited to two ears per year (annual maximum of $1500 per covered member)
- Annual Dental Evaluation (Adult/Child)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For information regarding those agencies contact: Government Employee Benefit Services at 954-357-6700. 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: Community Care Plan, Member Services at 866-224-5701.

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:

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[Spanish (Español): Para obtener asistencia en Español, llame al (866) 224-5701
[Creole: Pou asistans nan kreyòl, rele (866) 224-5701

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	$1300
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$1,300
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	$1300
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$1300
Copayments	$660
Coinsurance	$350
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2370**

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

The plan's overall deductible	$1300
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$840
Copayments	$150
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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