**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<br>In-network: **$500** / **$1,000**<br>Out-of-network: **$3,000** / **$6,000** | 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 care is covered before you meet your deductible. | 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.<br>For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered 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?** | Yes. Individual / Family<br>In-network: **$2,000** / **$4,000**<br>Out-of-network **$10,000** / **$20,000** | 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?** | Prior authorization penalties, balance billed charges (unless balanced billing is prohibited), premiums, and health care services this plan does not 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 | 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- |

| | | |
|---|---|---|
| | CCP.CustomerSvc@ccpcares.org,or **call 954-622-3499** | 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 permission from this plan. |

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% after Deductible | 40% after Deductible | None |
| | Specialist visit | 20% after Deductible | 40% after Deductible | Chiropractor: $40 copay/visit (60 visit maximum) |
| | Preventive care/screening/ immunization | 0% Coinsurance | 0% to $150 maximum then deductible and 40% | 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) | 20% after Deductible | 40% after Deductible | None |
| | Imaging (CT/PET scans, MRIs) | 20% after Deductible | 40% after Deductible | MRI, CT/PET scans require prior authorization |
| **If you need drugs to treat your illness or condition**<br><br>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, $30 copay **90 day retail** supply, $20 copay / 90 day **mail- order** supply | Not Covered | None |
| | Preferred brand drugs | $35 copay / 30 day **retail** supply, $105 copay **90 day retail** supply, $70 copay / 90 day **mail- order** supply | Not Covered | None |
| | Non-preferred brand drugs | 40% ($50 minimum, $150 maximum) / 30 day **retail** prescription, 40% ($150 minimum, $450 maximum **90 day retail supply**, 40% ($70 minimum, $210 maximum) / 90 day **mail- order** supply | Not Covered | 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. |

[* 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) | |
| | 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) | 20% after deductible | 40% after Deductible | Some services may require prior authorization. |
| | Physician/surgeon fees | 20% after deductible | 40% after Deductible | None |
| **If you need immediate medical attention** | Emergency room care | 20% after Deductible | 20% after Deductible | None |
| | Emergency medical transportation | 20% after Deductible | 20% after Deductible | Non-emergency transportation requires prior authorization |
| | Urgent care | 20% after Deductible | 40% after Deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after Deductible | 40% after Deductible | Requires prior authorization |
| | Physician/surgeon fees | 20% after Deductible | 40% after Deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 Copay/visit | 40% after Deductible | None |
| | Inpatient services | 20% after Deductible | 40% after Deductible | Requires prior authorization |
| **If you are pregnant** | Office visits | 20% after Deductible | 40% after Deductible | No prior authorization required for initial visit, but is required thereafter |
| | Childbirth/delivery professional services | 20% after Deductible | 40% after Deductible | None. |
| | Childbirth/delivery facility services | 20% after Deductible | 40% after Deductible | Requires prior authorization |
| **If you need help recovering or have other special health needs** | Home health care | 20% after Deductible | 40% after Deductible | Requires prior authorization; limited to 60 visits per calendar year. |
| | Rehabilitation services | 20% after Deductible<br><br>Cardiac Rehabilitation covered in Full | Not Covered | Physical therapy, occupational therapy and speech therapy visits are limited to sixty (60) visits per calendar year<br><br>Cardiac Therapy is limited to 36 visits per episode. |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | 20% after Deductible | 40% after Deductible | Requires prior authorization; limited to 45 days per calendar year. |

[* 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) | |
| | Durable medical equipment | 20% after Deductible | 40% after Deductible | Some services may require prior authorization. Subject to medical necessity review |
| | Hospice services | 20% after Deductible | 40% after Deductible | 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 | 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. |

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

## 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
- Bariatric surgery
- Chiropractic care
- Hearing aids

**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 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**

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 (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 | $500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 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 | $500 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,060** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 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 | $500 |
| Copayments | $770 |
| Coinsurance | $240 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,570** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 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 | $500 |
| Copayments | $0 |
| Coinsurance | $380 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$880** |

Examples assume individual coverage received from an in-network provider
The plan would be responsible for the other costs of these EXAMPLE covered services.