


Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE only, EE/Spouse, EE/Child(ren), EE/Family | Plan Type: HMO

 **This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at chcflorida.com or by calling 1-855-449-2889.**

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In network: \$1,750 person/\$3,500 family. Does not apply to PCP, First 5 Specialist visits, Urgent Care, First 3 visits ER visits, ER Transportation/Ambulance, Prenatal office visits, Advanced Imaging in freestanding facility, Preventive Care and Pediatric Vision Screening and Eye Out of network: Not Covered	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes \$250 Prescription. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	In network: Yes \$5,000 person/\$10,000 family Out of network: Not Covered	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, excluded services and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes For a list of participating providers, see chcflorida.com or call 1-855-449-2889.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	Yes	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .

Important Questions	Answers	Why This Matters:
Are there services this plan doesn't cover?	Yes. Some of the services this plan doesn't cover are listed in Services Your Plan Does Not Cover. See your Certificate of Coverage for additional information about excluded services.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$5 co-payment (co-pay)/occurrence	Not Covered	-----none-----
	Specialist visit	\$50 co-pay/occurrence	Not Covered	-----none-----
	Other practitioner office visit	\$50 co-pay/occurrence (chiropractic care).	Not Covered	Limited: 26 visits/year
	Preventive care/ Screening/Immunization	No Charge	Not Covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	\$0 in PCP office x-ray \$0 in PCP office lab	Not Covered x-ray Not Covered lab	-----none-----
	Imaging (CT/PET scans, MRIs)	\$250 co-pay/occurrence at freestanding facility	Not Covered	Not covered without preauthorization (preauth)

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at chcflorida.com.	Generic drugs	\$5 co-pay/fill retail preferred, \$10 co-pay/fill retail non preferred, \$10 co-pay/fill mail.	Not Covered	Includes \$3 co-pay/fill retail preferred generics, \$10 co-pay/fill retail non preferred, \$6 co-pay/fill mail. Limited: 30-day supply retail, 90-day supply mail. May require preauth for coverage.
	Preferred brand drugs	\$30 co-pay/fill retail preferred, \$75 co-pay/fill mail.	Not Covered	\$40 co-pay/fill retail non preferred, \$75 co-pay/fill mail. Limited: 30-day supply retail, 90-day supply mail. May require preauth for coverage.
	Non-preferred brand drugs	\$60 co-pay/fill retail preferred, \$180 co-pay/fill mail.	Not Covered	\$75 co-pay/fill retail non preferred, \$180 co-pay/fill mail. Limited: 30-day supply retail, 90-day supply mail. May require preauth for coverage.
	Specialty drugs	20% co-ins retail preferred	Not Covered	30% co-ins retail non preferred. Limited: 30-day supply. May require preauth for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 co-pay/occurrence at Freestanding Facility	Not Covered	-----none-----
	Physician/surgeon fees	20% co-ins	Not Covered	-----none-----
If you need immediate medical attention	Emergency room services	\$250 co-pay/occurrence	\$250 co-pay/occurrence	Must meet emergency room criteria.
	Emergency medical transportation	\$500 co-pay/occurrence	\$500 co-pay/occurrence	-----none-----
	Urgent care	\$75 co-pay/occurrence	Not Covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	Not Covered	Consequence for no preauth if required.
	Physician/surgeon fee	20% co-ins	Not Covered	Consequence for no preauth if required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 co-pay/occurrence	Not Covered	Limited: 20 visits/year.
	Mental/Behavioral health inpatient services	20% co-ins	Not Covered	Limited: 30 days/year and consequence for no preauth if required.
	Substance use disorder outpatient services	\$50 co-pay/occurrence	Not Covered	Limited: 20 visits/year.

SNO: 1202018 SBC Name: 017_72600 017_15971 017_4051

Questions: Call 1-855-449-2889 or visit us at chcflorida.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf> or call 1-855-449-2889 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder inpatient services	20% co-ins	Not Covered	Limited: 30 days/year and consequence for no preauth if required.
If you are pregnant	Prenatal and postnatal care	\$0	Not Covered	One time \$250 Co-pay Physician Services/Ultrasound
	Delivery and all inpatient services	20% co-ins	Not Covered	Consequence for no preauth if required.
If you need help recovering or have other special health needs	Home health care	20% co-ins	Not Covered	Limited: 20 visits/year and consequence for no preauth if required.
	Rehabilitation services	Inpatient 20% co-ins Outpatient 20% co-ins	Inpatient Not Covered Outpatient Not Covered	Consequence for no preauth if required.
	Habilitation services	20% co-ins	Not Covered	Consequence for no preauth if required.
	Skilled nursing care	20% co-ins	Not Covered	Limited: 60 days/year and consequence for no preauth if required.
	Durable medical equipment	20% co-ins	Not Covered	Consequence for no preauth if required.
	Hospice Service	20% co-ins	Not Covered	Consequence for no preauth if required.
If your child needs dental or eye care	Eye exam	\$0	Not Covered	Limited: 1 routine eye exam/year.
	Glasses	\$0	Not Covered	Limited: 1 pair eyeglasses/lenses/year. 1 frame/year.
	Dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Private-Duty Nursing
- Weight Loss Programs
- Bariatric Surgery
- Dental Care (Adult)
- Long-Term Care
- Routine Eye Care (Adult)
- Child/Dental Check-up
- Hearing Aids
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-449-2889. You may also contact your state insurance department, 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For group health coverage subject to ERISA, you may contact 1-855-449-2889. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or your state department of insurance at Florida Department of Financial Services Division of Consumer Services 200 E. Gaines St. Tallahassee, FL 32399-0322 877-693-5236 www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-855-449-2889 or your state department of insurance at Florida Department of Financial Services Division of Consumer Services 200 E. Gaines St. Tallahassee, FL 32399-0322 877-693-5236 www.myfloridacfo.com/Division/Consumers/NeedOurHelp.htm.

Does this Coverage Provide Minimum Essential Coverage?

SNO: 1202018 SBC Name: 017_72600 017_15971 017_4051

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-449-2889.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-449-2889.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-449-2889.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-449-2889.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$4,930
- **You pay:** \$2,610

Sample care costs:

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital Charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

You pay:

Deductibles	\$1,800
Co-pays	\$10
Coinsurance	\$600
Limits or exclusions	\$200
Total	\$2,610

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,760
- **You pay:** \$1,640

Sample care costs:

Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccine, other preventive	\$100
Total	\$5,400

You pay:

Deductibles	\$300
Co-pays	\$1,300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,640

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-855-449-2889

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.