Focused Silver (FS06)

The Schedule of Benefits is a summary of services that may be covered under the plan. Benefits listed are subject to all provisions and limitations as outlined in the Evidence of Coverage (EOC). Please refer to the EOC for details regarding the benefits listed below. The member is responsible for deductible, copayment or coinsurance applied to eligible service expenses. For services that require prior authorization, network providers must obtain authorization from us prior to providing a service or supply to a member. You should confirm with your provider that they have received prior authorization for a covered service prior to your treatment. An overview of Preventive Services covered with no cost share can be found within your EOC or at healthcare.gov/coverage/preventive-care-benefits.

Pursuant to the Federal No Surprises Act and applicable state law, you are only required to pay the in-network cost sharing for non-network emergency care, including air ambulance services; for certain ancillary services provided by non-network providers at in-network facilities; and for covered services by a non-network provider at an in- network facility when you do not provide informed consent. Charges you incur for services from a non-network provider that fall in the scenarios listed above will accumulate towards your in-network deductible and/or maximum out-of-pocket amount. Please refer to your EOC for further information.

Benefit	**Insured Responsibility (per person)**	
	In-Network Providers	**Out-of-Network Providers**
Annual Deductible per Calendar Year	$100 Individual $200 Family	Not applicable Individual; Not applicable Family
Coinsurance for Eligible Expenses (unless otherwise noted)	10%	Not applicable
Out-of-Pocket Maximum per Calendar Year	$2,500 Individual $5,000 Family	Not applicable Individual; Not applicable Family
Provider Office Services		
Primary Care Office Visit	No Charge	Not covered
Specialist Office Visit	10% Coinsurance after deductible	Not covered

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Preventive Care (including screenings, immunizations and well-baby visits) Covered in accordance with ACA guidelines.	No charge	Not covered
Diagnostic Test* (x-ray)	10% Coinsurance after deductible	Not covered
Diagnostic Test* Lab-work/Other (e.g., bloodwork, EKG, Stress Test)	10% Coinsurance after deductible	Not covered
Imaging Test* (CT/PET scans, MRI)	10% Coinsurance after deductible	Not covered
Prescription Drugs		
Tier 1a: Preferred Generic	No Charge	Not covered
Tier 1b: Generic*	No Charge	Not covered
Tier 2: Preferred Brand*	10% Coinsurance after deductible	Not covered
Tier 3: Non-Preferred Brand and Non-Preferred Generic*	10% Coinsurance after deductible	Not covered
Tier 4: Specialty*	10% Coinsurance after [[deductible|https:perperwww.healthcare.govpersbc-glossaryper#deductible	Not covered
Mail Order* (90-day supply)	10% Coinsurance after deductible	Not covered
Outpatient Services		
Outpatient Facility*	10% Coinsurance after deductible	Not covered
Outpatient Surgery Physician/Surgical Services*	10% Coinsurance after deductible	Not covered
Emergency and Urgent Care Services		
Emergency Room	10% Coinsurance after deductible	10% Coinsurance after deductible
ER Physician Fee	10% Coinsurance after deductible	10% Coinsurance after deductible
Emergency Transportation/Ambulance (Air, Water or Ground) Note: Prior authorization is not required for emergency transport, however, all non- emergent transport requires prior authorization.	10% Coinsurance after deductible	10% Coinsurance after deductible
Urgent Care or Virtual Urgent Care	10% Coinsurance after [[deductible|https:perperwww.healthcare.govpersbc-glossaryper#deductible	Not covered
Inpatient Hospital Services		

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Inpatient Hospital Facility*	10% Coinsurance after deductible	Not covered
Inpatient Hospital Physician and Surgical Services*	10% Coinsurance after deductible	Not covered
Behavioral Health Treatment: Mental Health and Substance Use Disorder Services		
Behavioral Health Outpatient Services* (PCP and other practitioner office visits do not require prior authorization.)	No Charge	Not covered
Behavioral Health Inpatient Services*	10% Coinsurance after deductible	Not covered
Behavioral Health Emergency Room	10% Coinsurance after deductible	10% Coinsurance after deductible
Behavioral Health ER Physician Fee	10% Coinsurance after deductible	10% Coinsurance after deductible
Behavioral Health Emergency Transportation/Ambulance (Air, Water or Ground) Note: Prior authorization is not required for emergency transport, however, all non- emergent transport requires prior authorization.	10% Coinsurance after deductible	10% Coinsurance after deductible
Behavioral Health Urgent Care	10% Coinsurance after [[deductible|https:perperwww.healthcare.govpersbc-glossaryper#deductible	Not covered
Behavioral Health Laboratory Services*	10% Coinsurance after deductible	Not covered
Behavioral Health Habilitation Outpatient Services* (Including occupational, speech, and physical therapy)	10% Coinsurance after deductible	Not covered
Behavioral Health Habilitation Inpatient Services* (Including occupational, speech, and physical therapy)	10% Coinsurance after deductible	Not covered
Substance Abuse Disorder Inpatient Services	10% Coinsurance after deductible	Not covered
Substance Abuse Disorder Outpatient Services	10% Coinsurance after deductible	Not covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	No Charge	Not covered
Delivery and Inpatient Services*	10% Coinsurance after deductible	Not covered

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Other Covered Services		
Home Health Care Services* Limited to 20 visits per year.	10% Coinsurance after deductible	Not covered
Outpatient Rehabilitation Services* (Including speech, occupational, cardiac and physical therapy) Outpatient rehabilitation therapy is limited to a combined 35 visits per year, including chiropractic care. Note: Limits do not apply when provided for a mental health/ substance use disorder diagnosis.	10% Coinsurance after deductible	Not covered
Inpatient Rehabilitation Services* (Including speech, occupational, cardiac and physical therapy) Limited to 21 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	10% Coinsurance after deductible	Not covered
Habilitation Outpatient Services* (Including speech, occupational, cardiac and physical therapy) Outpatient habilitation therapy is limited to a combined 35 visits per year, including chiropractic care.	10% Coinsurance after deductible	Not covered
Habilitation Inpatient Services* (Including speech, occupational, cardiac and physical therapy) Limited to 21 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.	10% Coinsurance after deductible	Not covered
Skilled Nursing Facility* Limited to 60 days per year.	10% Coinsurance after [[deductible|https:perperwww.healthcare.govpersbc-glossaryper#deductible	Not covered
Durable Medical Equipment*	10% Coinsurance after deductible	Not covered
Hospice Services*	10% Coinsurance after deductible	Not covered
Chiropractic Care* Limited to a combined 35 visits per year, including outpatient therapy.	10% Coinsurance after deductible	Not covered
Diabetes Care Management	No Charge	Not covered

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Temporomandibular Joint Disorder (TMJ)*	10% Coinsurance after deductible	Not covered
Laboratory Outpatient and Professional Services	10% Coinsurance after deductible	Not covered
Accidental Dental	10% Coinsurance after deductible	Not covered
Dialysis	10% Coinsurance after deductible	Not covered
Allergy Testing	10% Coinsurance after deductible	Not covered
Chemotherapy	10% Coinsurance after deductible	Not covered
Radiation	10% Coinsurance after deductible	Not covered
Prosthetic Devices	10% Coinsurance after deductible	Not covered
Nutritional Counseling	10% Coinsurance after deductible	Not covered
Reconstructive Surgery	10% Coinsurance after deductible	Not covered
Vision Services – Pediatric (Children under the age of 19)		
Exam		
Routine eye exam (& contact lens fitting) Limited to 1 visit per year.	100% Covered	Not covered
Standard Frame		
Eyeglasses (frames) Limited to 1 item per year.	100% Covered	Not covered
Lenses (per pair)		
Prescription lenses (including additional lens options)	100% Covered	Not covered
Contact lenses (in lieu of glasses)	100% Covered	Not covered

Statement of Non-Discrimination

Community Care Network, Inc. d/b/a 22 Health is a Qualified Health Plan issuer in the Florida Health Insurance Marketplace. This company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance.

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If you, or someone you're helping, have questions about Community Care Network, Inc. d/b/a 22 Health, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you're helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at [1-866-357-4082]. If you believe that Community Care Network, Inc. d/b/a 22 Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at [1-866-357-4082]. For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit ocrportal.hhs.gov/ocr/.

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