Standard Silver (S06)

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	$0 Individual $0 Family	Not applicable Individual; Not applicable Family
Coinsurance for Eligible Expenses (unless otherwise noted)	25%	Not applicable
Out-of-Pocket Maximum per Calendar Year	$2,200 Individual $4,400 Family	Not applicable Individual; Not applicable Family
Provider Office Services		
Primary Care Office Visit	No Charge	Not covered
Specialist Office Visit	$10 copay per visit	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

Preventive Care (including screenings, immunizations and well-baby visits) Covered in accordance with ACA guidelines.	No charge	Not covered
Diagnostic Test* (x-ray)	25%	Not covered
Diagnostic Test* Lab-work/Other (e.g., bloodwork, EKG, Stress Test)	25%	Not covered
Imaging Test* (CT/PET scans, MRI)	25%	Not covered
Prescription Drugs		
Tier 1a: Preferred Generic	No Charge	Not covered
Tier 1b: Generic*	No Charge	Not covered
Tier 2: Preferred Brand*	$15	Not covered
Tier 3: Non-Preferred Brand and Non-Preferred Generic*	$50	Not covered
Tier 4: Specialty*	$150	Not covered
Mail Order* (90-day supply)	$150	Not covered
Outpatient Services		
Outpatient Facility*	25%	Not covered
Outpatient Surgery Physician/Surgical Services*	25%	Not covered
Emergency and Urgent Care Services		
Emergency Room	25%	25%
ER Physician Fee	25%	25%
Emergency Transportation/Ambulance (Air, Water or Ground) Note: Prior authorization is not required for emergency transport, however, all non- emergent transport requires prior authorization.	25%	25%
Urgent Care or Virtual Urgent Care	$5 copay per visit	Not covered
Inpatient Hospital Services		
Inpatient Hospital Facility*	25%	Not covered
Inpatient Hospital Physician and Surgical Services*	25%	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*	25%	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

Behavioral Health Emergency Room	25%	25%
Behavioral Health ER Physician Fee	25%	25%
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.	25%	25%
Behavioral Health Urgent Care	$5 copay per visit	Not covered
Behavioral Health Laboratory Services*	25%	Not covered
Behavioral Health Habilitation Outpatient Services* (Including occupational, speech, and physical therapy)	25%	Not covered
Behavioral Health Habilitation Inpatient Services* (Including occupational, speech, and physical therapy)	No Charge	Not covered
Substance Abuse Disorder Inpatient Services	25%	Not covered
Substance Abuse Disorder Outpatient Services	25%	Not covered
Maternity and Newborn Care		
Prenatal and Postnatal Care	No Charge	Not covered
Delivery and Inpatient Services*	25%	Not covered
Other Covered Services		
Home Health Care Services* Limited to 20 visits per year.	25%	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.	25%	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	25%	Not covered

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

mental health/substance use disorder diagnosis.		
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.	No Charge	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.	25%	Not covered
Skilled Nursing Facility* Limited to 60 days per year.	25%	Not covered
Durable Medical Equipment*	25%	Not covered
Hospice Services*	25%	Not covered
Chiropractic Care* Limited to a combined 35 visits per year, including outpatient therapy.	$10	Not covered
Diabetes Care Management	No Charge	Not covered
Temporomandibular Joint Disorder (TMJ)*	$10	Not covered
Laboratory Outpatient and Professional Services	25%	Not covered
Accidental Dental	$10	Not covered
Dialysis	25%	Not covered
Allergy Testing	25%	Not covered
Chemotherapy	25%	Not covered
Radiation	25%	Not covered
Prosthetic Devices	25%	Not covered
Nutritional Counseling	$10	Not covered
Reconstructive Surgery	25%	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		

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.

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.

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/.

*Prior authorization may be required. Please contact Member Services at the number listed on your member identification card to determine if prior authorization is needed.