

## Smart Silver (SS03)

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](http://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                         |
| <b>Annual Deductible per Calendar Year</b>                        | \$5,000 Individual<br>\$10,000 Family | Not applicable Individual; Not applicable Family |
| <b>Coinsurance for Eligible Expenses (unless otherwise noted)</b> | 40%                                   | Not applicable                                   |
| <b>Out-of-Pocket Maximum per Calendar Year</b>                    | \$7,500 Individual<br>\$15,000 Family | Not applicable Individual; Not applicable Family |
| <b>Provider Office Services</b>                                   |                                       |                                                  |
| Primary Care Office Visit                                         | \$25 copay per visit                  | Not covered                                      |
| Specialist Office Visit                                           | \$70 copay per visit after deductible | 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)<br>Covered in accordance with ACA guidelines.                                                                          | No charge                        | Not covered                      |
| Diagnostic Test* (x-ray)                                                                                                                                                                          | 40% Coinsurance after deductible | Not covered                      |
| Diagnostic Test* Lab-work/Other (e.g., bloodwork, EKG, Stress Test)                                                                                                                               | 40% Coinsurance after deductible | Not covered                      |
| Imaging Test* (CT/PET scans, MRI)                                                                                                                                                                 | 40% Coinsurance after deductible | Not covered                      |
| <b>Prescription Drugs</b>                                                                                                                                                                         |                                  |                                  |
| Tier 1a: Preferred Generic                                                                                                                                                                        | \$40                             | Not covered                      |
| Tier 1b: Generic*                                                                                                                                                                                 | \$40                             | Not covered                      |
| Tier 2: Preferred Brand*                                                                                                                                                                          | \$50                             | Not covered                      |
| Tier 3: Non-Preferred Brand and Non-Preferred Generic*                                                                                                                                            | 50% Coinsurance after deductible | Not covered                      |
| Tier 4: Specialty*                                                                                                                                                                                | 50% Coinsurance after deductible | Not covered                      |
| Mail Order* (90-day supply)                                                                                                                                                                       | 50% Coinsurance after deductible | Not covered                      |
| <b>Outpatient Services</b>                                                                                                                                                                        |                                  |                                  |
| Outpatient Facility*                                                                                                                                                                              | 40% Coinsurance after deductible | Not covered                      |
| Outpatient Surgery Physician/Surgical Services*                                                                                                                                                   | 40% Coinsurance after deductible | Not covered                      |
| <b>Emergency and Urgent Care Services</b>                                                                                                                                                         |                                  |                                  |
| Emergency Room                                                                                                                                                                                    | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| ER Physician Fee                                                                                                                                                                                  | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Emergency Transportation/Ambulance (Air, Water or Ground)<br>Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Urgent Care or Virtual Urgent Care                                                                                                                                                                | \$60 copay per visit             | Not covered                      |
| <b>Inpatient Hospital Services</b>                                                                                                                                                                |                                  |                                  |
| Inpatient Hospital Facility*                                                                                                                                                                      | 40% Coinsurance after deductible | Not covered                      |
| Inpatient Hospital Physician and Surgical Services*                                                                                                                                               | 40% Coinsurance after deductible | Not covered                      |

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| <b>Behavioral Health Treatment: Mental Health and Substance Use Disorder Services</b>                                                                                                                               |                                  |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|
| Behavioral Health Outpatient Services*<br>(PCP and other practitioner office visits do not require prior authorization.)                                                                                            | \$25 copay per visit             | Not covered                      |
| Behavioral Health Inpatient Services*                                                                                                                                                                               | 40% Coinsurance after deductible | Not covered                      |
| Behavioral Health Emergency Room                                                                                                                                                                                    | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Behavioral Health ER Physician Fee                                                                                                                                                                                  | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Behavioral Health Emergency Transportation/Ambulance (Air, Water or Ground)<br>Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. | 40% Coinsurance after deductible | 40% Coinsurance after deductible |
| Behavioral Health Urgent Care                                                                                                                                                                                       | \$60 copay per visit             | Not covered                      |
| Behavioral Health Laboratory Services*                                                                                                                                                                              | 40% Coinsurance after deductible | Not covered                      |
| Behavioral Health Habilitation Outpatient Services* (Including occupational, speech, and physical therapy)                                                                                                          | 40% Coinsurance after deductible | Not covered                      |
| Behavioral Health Habilitation Inpatient Services*<br>(Including occupational, speech, and physical therapy)                                                                                                        | \$70 Copay after deductible      | Not covered                      |
| Substance Abuse Disorder Inpatient Services                                                                                                                                                                         | 40% Coinsurance after deductible | Not covered                      |
| Substance Abuse Disorder Outpatient Services                                                                                                                                                                        | 40% Coinsurance after deductible | Not covered                      |
| <b>Maternity and Newborn Care</b>                                                                                                                                                                                   |                                  |                                  |
| Prenatal and Postnatal Care                                                                                                                                                                                         | \$25 copay per visit             | Not covered                      |
| Delivery and Inpatient Services*                                                                                                                                                                                    | 40% Coinsurance after deductible | Not covered                      |
| <b>Other Covered Services</b>                                                                                                                                                                                       |                                  |                                  |
| Home Health Care Services*<br>Limited to 20 visits per year.                                                                                                                                                        | 40% Coinsurance after deductible | Not covered                      |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------|
| Outpatient Rehabilitation Services*<br>(Including speech, occupational, cardiac and physical therapy)<br>Outpatient rehabilitation therapy is limited to a combined 35 visits per year, including chiropractic care.<br>Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis. | 40% Coinsurance after deductible | Not covered |
| Inpatient Rehabilitation Services*<br>(Including speech, occupational, cardiac and physical therapy)<br>Limited to 21 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.                                                                                    | 40% Coinsurance after deductible | Not covered |
| Habilitation Outpatient Services*<br>(Including speech, occupational, cardiac and physical therapy)<br>Outpatient habilitation therapy is limited to a combined 35 visits per year, including chiropractic care.                                                                                                      | 40% Coinsurance after deductible | Not covered |
| Habilitation Inpatient Services*<br>(Including speech, occupational, cardiac and physical therapy)<br>Limited to 21 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.                                                                                      | 40% Coinsurance after deductible | Not covered |
| Skilled Nursing Facility*<br>Limited to 60 days per year.                                                                                                                                                                                                                                                             | \$700 Copay per Day              | Not covered |
| Durable Medical Equipment*                                                                                                                                                                                                                                                                                            | 40% Coinsurance after deductible | Not covered |
| Hospice Services*                                                                                                                                                                                                                                                                                                     | 40% Coinsurance after deductible | Not covered |
| Chiropractic Care*<br>Limited to a combined 35 visits per year, including outpatient therapy.                                                                                                                                                                                                                         | \$70 Copay after deductible      | Not covered |
| Diabetes Care Management                                                                                                                                                                                                                                                                                              | \$25 copay per visit             | Not covered |
| Temporomandibular Joint Disorder (TMJ)*                                                                                                                                                                                                                                                                               | \$70 Copay after deductible      | Not covered |
| Laboratory Outpatient and Professional Services                                                                                                                                                                                                                                                                       | 40% Coinsurance after deductible | Not covered |

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|                                                                           |                                  |             |
|---------------------------------------------------------------------------|----------------------------------|-------------|
| Accidental Dental                                                         | \$70 Copay after deductible      | Not covered |
| Dialysis                                                                  | 40% Coinsurance after deductible | Not covered |
| Allergy Testing                                                           | 40% Coinsurance after deductible | Not covered |
| Chemotherapy                                                              | 40% Coinsurance after deductible | Not covered |
| Radiation                                                                 | 40% Coinsurance after deductible | Not covered |
| Prosthetic Devices                                                        | 40% Coinsurance after deductible | Not covered |
| Nutritional Counseling                                                    | \$70 Copay after deductible      | Not covered |
| Reconstructive Surgery                                                    | 40% Coinsurance after deductible | Not covered |
| <b>Vision Services – Pediatric (Children under the age of 19)</b>         |                                  |             |
| Exam                                                                      |                                  |             |
| Routine eye exam (& contact lens fitting)<br>Limited to 1 visit per year. | 100% Covered                     | Not covered |
| Standard Frame                                                            |                                  |             |
| Eyeglasses (frames) Limited<br>to 1 item per year.                        | 100% Covered                     | Not covered |
| Lenses (per pair)                                                         |                                  |             |
| Prescription lenses (including<br>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

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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/](https://ocrportal.hhs.gov/ocr/).

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