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 https://daytona.healthsmart.com/pages/login.aspx or by calling 1-855-224-5173. For Pharmacy contact Catamaran Rx at www.mycatamaranrx.com/PortalCentral/index.jsp or by calling 1-800-207-2568.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **NA** Expanded Network: **$500** per person /**$1,500** per family (doesn't apply to preventive care and pharmaceutical benefits); Out-of-Network:**$2,000** per person / **$6,000** per family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	**Yes. $250** per person /**$750** per family for In-Network CT/MRI deductible	You have to meet **deductibles** for specific services, see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes** In-Network and Expanded Network: **$5,000** per person / **$10,000** family; Out-of-Network: **$10,000** per person /**$20,000** family	The **out-of-pocket limit** 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 out–of–pocket limit?	Deductibles, Premiums, Balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes** For a list of preferred providers, see https://daytona.healthsmart.com/pages/login.aspx or call 1-855-224-5173	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes**	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**.

- **Copayments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 Florida Memorial Health Network, Volusia Health Network, and Florida Memorial Health Network Expanded Network (FHHS) 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	Expanded Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/ visit	deductible+20% coinsurance	deductible+40% coinsurance	——————none——————
	Specialist visit	$40 copay/ visit	deductible+20% coinsurance	deductible+40% coinsurance	——————none——————
	Other practitioner office visit (Chiropractor)	$25 copay for chiropractor	deductible+20% coinsurance for chiropractor	deductible+40% coinsurance for chiropractor	Precertification is required after 12 visits – call DPSC at 386-615-0801. Penalties for failure to get precertification include denial of benefits or $250 penalty per occurrence. Non-surgical spinal decompression is not covered.
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work, PET scans)	$25 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	——————none——————
	Imaging (CT/MRIs)	deductible+10% coinsurance	deductible+20% coinsurance	deductible+40% coinsurance	You must pay all the costs for CT and MRI's up to the **deductible** and applicable coinsurance amount.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Expanded Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mycatamaranrx.com/PortalCentral/index.jsp**	Generic drugs	$20 copay retail/$40 copay via mail 31 to 90 day supply		50% coinsurance	Covers up to a 30-day retail supply or 31-90 day mail order supply
	Preferred brand drugs	$35 copay retail/$70 copay via mail 31to 90 day supply		50% coinsurance	Covers up to a 30-day retail supply or 31-90 day mail order supply
	Non-preferred brand drugs	$55 copay retail/$110 copay via mail 31 to 90-day supply		50% coinsurance	Covers up to a 30-day retail supply or 31-90 day mail order supply
	Specialty drugs – Generic Preferred brand drugs Non-preferred brand drugs DAW 1 DAW 2	$20 copay $35 copay $55 copay $55 copay + difference from generic $55 copay + difference from generic		50% coinsurance	Medications will only be dispensed for a 30 days supply, at a 30 day retail co-pay at the following pharmacies: Catamaran Home Delivery, Catamaran National Retail Network, Diabetic Sense Pharmacy, Briova Specialty Pharmacy, Catamaran Specialty Network (with exclusions)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	Precertification is required call KePro at1-888-522-7742
	Physician/surgeon fees	$40 copay	deductible+20% coinsurance	deductible+40% coinsurance	
If you need immediate medical attention	Emergency room services	$65 copay - waived if admitted	20% coinsurance	40% coinsurance	————————none————————
	Emergency medical transportation	$65 copay	deductible+20% coinsurance	deductible+40% coinsurance	————————none————————
	Urgent care	$50 copay	20% coinsurance	40% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per day for 3 days	deductible+20% coinsurance	deductible+40% coinsurance	Precertification is required call KePro at1-888-522-7742
	Physician/surgeon fee	No charge	deductible+20% coinsurance	deductible+40% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Expanded Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	Precertification is required for all Inpatient Mental/Behavioral health and substance abuse services. Precertification is required call KePro at1-888-522-7742. Penalties for failure to obtain precertification are $1000 penalty per inpatient admission or denial of benefits.
	Mental/Behavioral health inpatient services	$250 copay per day for 3 days	deductible+20% coinsurance	deductible+40% coinsurance	
	Substance use disorder outpatient services	$25 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	
	Substance use disorder inpatient services	$250 copay per day for 3 days	deductible+20% coinsurance	deductible+40% coinsurance	
If you are pregnant	Prenatal and postnatal care	$40 copay for 1st prenatal visit + $250 copay/day facility up to 3 days + $105 copay for OB doctor	deductible+20% coinsurance	deductible+40% coinsurance	Coverage only for insured or spouse
	Delivery and all inpatient services				No coverage for birthing center facility charges.
If you need help recovering or have other special health needs	Home health care	No charge	deductible+20% coinsurance	deductible+40% coinsurance	Precertification is required. Contact KePro at 1-888-522-7742. Penalties for failure to get precertification include denial of benefits or $250 penalty per occurrence. Precertification is required for DME for $250 & over per item.
	Rehabilitation services	$25 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	
	Habilitation services	$25 copay/visit	deductible+20% coinsurance	deductible+40% coinsurance	
	Skilled nursing facility	$55 copay per admission	deductible+20% coinsurance	deductible+40% coinsurance	
	Durable medical equipment	$25 copay	deductible+20% coinsurance	deductible+40% coinsurance	
	Hospice service	No charge	deductible+20% coinsurance	deductible+40% coinsurance	
If your child needs dental or eye care	Vision and Hearing Exams	All charges above $50			Limited to exams; screenings are no charge.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Expanded Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
	Glasses (to include frames and lenses)	All charges above $125	All charges above $125	All charges above $125	You **MUST** be enrolled in the separate Vision Plan to receive this benefit.
	Dental Check-up/Type I - Preventive	No charge	No charge	No charge	Calendar Year Limits do not apply to Pediatric Oral Preventive Services; does not include Orthodontic Services

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
- Hair replacement, unless as a result of radiation or chemotherapy treatments
- Long-term care
- Routine Eye Examinations – (see Vision Plan)
- Weight loss programs
- Bariatric surgery
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Worker's compensation claims
- Cosmetic surgery
- In-vito or in-vitro fertilization
- Pregnancy of dependent children
- Private-duty nursing
- Sex change surgery or other gender dysfunction treatments

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
- Elective Sterilization
- Dental Care (adult)
- Fertility studies and diagnostic procedures (limited to $2,000)
- Diabetic supplies
- Hospice 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.)

- Organ or tissue transplant
- Mastectomy procedures, including breast reconstruction and prostheses
- Massage therapy if physician ordered

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 1-855-224-5173. 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: HealthSmart Benefit Solutions at 1-855-224-5173. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol/gov/ebsa/healthreform. You may also contact the Florida Office of Insurance Regulation at 1-850-413-3140 or www.floir.com.

Does this Coverage Provide Minimum Essential Coverage?

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 1-855-224-5173.

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 financial protection a sample patient might get if they are covered under 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** $6,650
- **Patient pays** $890

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**
Patient pays:	
Deductible	$0
Copayments	$740
Coinsurance	$0
Limits or exclusions	$150
Total	**$890**

Note: These numbers assume individual coverage and the patient is using in-network providers. For more information, please contact 1-855-224-5173.

**Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about excluded services

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,690
- **Patient pays** $1,710

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductible	$0
Copayments	$1,630
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,710**

Note: These numbers assume individual coverage; the patient is using in-network providers. For more information please contact 1-855-224-5173.

**Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about excluded services

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.