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

Coverage for: Individual and/or Family | **Plan Type:** PPO

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 www.floridablue.com or by calling 1-800-825-2583. In the event there is a conflict between this summary and your Florida Blue Benefit Document the terms and conditions of the Benefit Document will control.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$250** Person/**$500** Family. Out-Of-Network: **$750** Person/**$1,500** Family. Does not apply to preventive care.	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** In-Network Per Admission Deductible; **$500** Out-Of-Network There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$7,150** Per Person/**$14,300** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (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?	Premium, balance-billed charges, non-network expenses; 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 **participating providers**, see www.floridablue.com or call 1-800-825-2583.	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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-825-2583 or visit us at www.floridablue.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 www.myBenefits.myFlorida.com or call People First at 1-866-663-4735 to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) 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 in-network **providers** by charging you lower **deductibles**, **copays** 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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay	40% Coinsurance	————none————
	Specialist visit	$25 Copay	40% Coinsurance	————none————
	Other practitioner office visit	$25 Copay	40% Coinsurance	————none————
	Preventive care/ screening/immunization	No Charge	Only amount above allowance	Age and gender based.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark/sofrxplan	Generic drugs	$7 retail/$14 mail	You pay in full and file claim, you will **not** be reimbursed the full amount.	You are required to use mail order or a participating 90-day retail pharmacy for maintenance medications after three refills at a 30-day retail pharmacy.
	Preferred brand drugs	$30 retail/$60 mail		
	Non-preferred brand drugs	$50 retail/ $100 mail		

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Specialty drugs	$14 Generic $60 Preferred $100 Non-preferred	You pay in full and file claim, you will **not** be reimbursed the full amount.	Must obtain through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Does not cover cosmetic or non-medically necessary surgery or complications from such surgeries.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
If you need immediate medical attention	Emergency room services	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	————none————
	Emergency medical transportation	No Charge	No Charge	Must be medically necessary.
	Urgent care	$25 Copay	$25 Copay	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance + $250 Per Admission Deductible	40% Coinsurance + $500 Per Admission Deductible	Admission Certification and Hospital Stay Certification required.
	Physician/surgeon fee	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Mental/Behavioral health inpatient services	20% Coinsurance + $250 Per Admission Deductible	40% Coinsurance + $500 Per Admission Deductible	Admission Certification and Hospital Stay Certification required
	Substance use disorder outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Substance use disorder inpatient services	20% Coinsurance + $250 Per Admission Deductible	40% Coinsurance + $500 Per Admission Deductible	Admission Certification and Hospital Stay Certification required
If you are pregnant	Prenatal and postnatal care	$25 Per visit	40% Coinsurance	————none————
	Delivery and all inpatient services	20% Coinsurance + $250 Per Admission Deductible	40% Coinsurance + $500 Per Admission Deductible	Admission Certification and Hospital Stay Certification required

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Must meet criteria. Does not include speech therapy or custodial care.
	Rehab services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Physical therapy and massage therapy, 4 treatments per day, 21 treatment days per six month period.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	30% Coinsurance	30% Coinsurance	Skilled Nursing Facility services are limited to 60 days per calendar year. Does not include custodial care.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Limited to the most standard model available to meet medical necessity.
	Hospice service	30% Coinsurance (inpatient); 20% Coinsurance (outpatient/home)	30% Coinsurance (inpatient); 20% Coinsurance (outpatient/home)	Coverage is limited to 210 days per person per lifetime.
If your child needs dental or eye care	Eye exam	$25 Copay	40% Coinsurance	————none————
	Glasses	Not Covered	Not Covered	————none————
	Dental check-up	Not Covered	Not Covered	————none————

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.)**

- Cosmetic surgery
- Complications resulting from cosmetic surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-medically necessary surgery
- Weight loss programs

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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine foot 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 People First Service Center at 1-866-663-4735. You may also contact your state insurance department at **1-877-693-5236**, 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: The Division of State Group Insurance at 1-850-921-4600; Florida Blue at 1-800-825-2583; or, The Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789.

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 **1-800-352-8583**.

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** $6,180
- **Patient pays** $1,360

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Lab tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$60
Coinsurance	$800
Limits or exclusions	$200
Total	**$1,360**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Lab tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$500
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,080**

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.
- If this Summary includes both individual and family coverage tiers, the coverage examples were completed using the per-person deductible and out-of-pocket limit on page 1.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, 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 **copays**, **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.

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