Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** HI PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/state-employees. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com or call 1-800-825-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,350** Per Person/**$2,700** Family. Out-of-Network: **$2,500** Per Person/**$5,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$1,000** Out-of-Network Per Admission Deductible. 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.
What is the out-of-pocket limit for this plan?	In-Network: **$4,350** Per Person/**$8,700** Family.	The out-of-pocket limit is the most you could pay in a year for covered in-network services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, 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.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-825-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check network status with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral from this plan.

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Specialist visit	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Preventive care/screening/ immunization	No Charge	Amount above allowance	Age and gender based.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------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	Deductible +30% retail and 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 of a 30-day supply at a retail (30-day) pharmacy.
	Preferred brand drugs	Deductible +30% retail and mail		
	Non-preferred brand drugs	Deductible + 50% retail and mail		
	Specialty drugs	Deductible + 30% Generic and Preferred Deductible + 50% Non-preferred		Must obtain through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Does not cover cosmetic or non-medically necessary surgery or complications from such surgeries.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	

If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance + amount above allowance	----------none----------
	Emergency medical transportation	Deductible	Deductible	Must be medically necessary.
	Urgent care	Deductible +20% Coinsurance	Deductible + 20% Coinsurance + amount above allowance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + $1,000 Per Admission Deductible + amount above allowance	Admission Certification and Hospital Stay Certification required.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Inpatient services	Physician Services: Deductible + 20% Coinsurance Hospital: Deductible + 20% Coinsurance	Physician Services: Deductible + 40% Coinsurance + amount above allowance Hospital: $1,000 Per Admission Deductible + 40% Coinsurance + amount above allowance	Admission Certification and Hospital Stay Certification required.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	$1,000 Per Admission Deductible + 40% Coinsurance + amount above allowance	Admission Certification and Hospital Stay Certification required.

If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Must meet criteria. Does not include speech therapy or custodial care. Occupational therapy is covered.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Physical therapy and massage therapy, 4 treatments per day, 21 treatment days per six month period. Occupational therapy limited to 21 treatment days per six month period.
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance + amount above allowance	Limited to 60 days per calendar year. Does not include custodial care.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Limited to the most standard model available to meet medical necessity.
	Hospice services	Deductible + 30% Coinsurance (inpatient) / Deductible + 20% Coinsurance (outpatient/home)	Deductible + 30% Coinsurance (inpatient) + amount above allowance/ Deductible + 20% Coinsurance + amount above allowance (outpatient/home)	Coverage limited to 210 days lifetime maximum per person/ occupational therapy is covered.
If your child needs dental or eye care	Children's eye exam	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	----------none----------
	Children's glasses	Not Covered	Not Covered	----------none----------
	Children's 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)
- Habilitation services
- 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. • Occupational therapy	• 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:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,350**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$110
The total Peg would pay is	**$3,660**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,350**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,110**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,350**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members)
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC1-7
Jacksonville, Florida 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-3852 (رقم هاتف الصم والبكم: 1-800-559-008-0778. اتصل برقم 1-800-333-008-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.