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| **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.**  Important Information Image**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, **www.[insert].com**. 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.[insert].com** or call 1-800-664-5295 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall deductible?** | In-Network: **$1,000** Per Person/**$2,000** Family. Out-of-Network: Combined with In-Network. Separate **$100/$200** Individual/Family Prescription Drug Deductible. | 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.7 |
| **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/](http://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other**  **deductibles for specific services?** | Yes. Prescription Drugs. | You must meet a $100 Individual of $200 Family deductible before receiving coverage for prescription drugs on this plan. |
| **What is the out-of-pocket limit for this plan?** | Yes. In-Network: **$5,850** Per Person/**$10,960** Family. Out-Of-Network: Combined with In-Network. Separate **$1,500/$2,740** Prescription Drug Out-of-Pocket Maximum. | The out-of-pocket limit is the most you could pay in a year for covered 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 1-800-664-5295 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 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. |

| **Important Information Image** | All copayment and 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 | Primary Care Visits: $30 Copay per Visit/ Virtual Visits (Telemedicine): $10 Copay per Visit/ Value Choice Provider: $5 Copay per Visit | Primary Care Visits: $40 Copay per Visit/ Virtual Visits (Telemedicine): Not Covered/ Value Choice Provider: Not Covered | Physician administered drugs may have higher cost shares. |
| Specialist visit | $30 Copay per Visit | $40 Copay per Visit | Physician administered drugs may have higher cost shares. |
| Preventive care/screening/  immunization | No Charge | $40 Copay per Visit | Physician administered drugs may have higher cost shares. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $50 Copay per Visit | Deductible + 40% Coinsurance | Tests performed in hospitals may have higher cost-share. |
| Imaging (CT/PET scans, MRIs) | $200 Copay per Visit | $200 Copay per Visit | Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied. |
|  |  | Retail/Mail |  |  |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.optumrx.com](http://www.optumrx.com) | Generic drugs | $10/$20 | Not Covered |  |
| Preferred brand drugs | $45/$90 | Not Covered |  |
| Non-preferred brand drugs | $60/$120 | Not Covered |  |
| Specialty drugs | Applicable Copay | Not Covered |  |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center: $200 Copay per Visit/ Hospital Option 1: Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Option 2 hospitals may have a higher cost-share. |
| Physician/surgeon fees | Ambulatory Surgical Center: $30 Copay per Visit/ Hospital: $50 Copay per Visit | Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: $50 Copay per Visit | ––––––––none–––––––– |
| **If you need immediate medical attention** | Emergency room care | $250 Copay per Visit | $250 Copay per Visit | ––––––––none–––––––– |
| Emergency medical transportation | Deductible + 25% Coinsurance | In-Network Deductible + 25% Coinsurance | ––––––––none–––––––– |
| Urgent care | Urgent Care Visits: $50 Copay per Visit/ Value Choice Provider: $0 Copay - Visits 1-2  $50 Copay for remaining Visits | Urgent Care Visits: Deductible + $50 Copay per Visit/ Value Choice Provider: Not Covered | ––––––––none–––––––– |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Hospital Option 1: Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share. |
| Physician/surgeon fees | $50 Copay per Visit | $50 Copay per Visit | ––––––––none–––––––– |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Physician Office: $30 Copay per Visit / Hospital Opt 1: Deductible + 25% Coinsurance | Physician Office: $40 Copay per Visit / Hospital: Deductible + 40% Coinsurance | Option 2 hospitals may have a higher cost-share. |
| Inpatient services | Physician Services: $30 Copay per Visit / Hospital Opt 1: Deductible + 25% Coinsurance | Physician Services: $40 Copay per Visit/ Hospital: Deductible + 40% Coinsurance | Prior Authorization may be required. Your benefits/services may be denied.Option 2 hospitals may have a higher cost-share. |
| **If you are pregnant** | Office visits | $30 Copay on initial Visit | $30 Copay per Visit | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | $50 Copay per Visit | $50 Copay per Visit | ––––––––none–––––––– |
| Childbirth/delivery facility services | Hospital Option 1: Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Option 2 hospitals may have a higher cost-share. |
| **If you need help recovering or have other special health needs** | Home health care | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Coverage limited to 30 visits. |
| Rehabilitation services | Physician Office: $30 Copay per Visit/ Outpatient Rehab Center: $45 Copay per Visit | Physician Office: $40 Copay per Visit/ Outpatient Rehab Center: Deductible + 40% Coinsurance | Coverage limited to 122 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied. |
| Habilitation services | Not Covered | Not Covered | Not Covered |
| Skilled nursing care | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Coverage limited to 60 days. |
| Durable medical equipment | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. |
| Hospice services | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | ––––––––none–––––––– |
| **If your child needs dental or eye care** | Children’s eye exam | Not Covered | Not Covered | Not Covered |
| Children’s glasses | Not Covered | Not Covered | Not Covered |
| Children’s dental check-up | Not Covered | Not Covered | Not Covered |

**Excluded Services & Other Covered Services:**

|  |  |  |
| --- | --- | --- |
| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |
| * Cosmetic surgery * Dental care (Adult) * Habilitation services * Infertility treatment | * Long-term care * Pediatric dental check-up * Pediatric eye exam * Pediatric glasses | * Private-duty nursing * Routine eye care (Adult) * Routine foot care unless for treatment of diabetes * Weight loss programs |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |
| * Acupuncture * Bariatric surgery | * Chiropractic care – Limited to 122 visits * Most coverage provided outside the United States. See www.floridablue.com. | * Non-emergency care when traveling outside the U.S. |

**Your Rights to Continue Coverage****:**  There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov/). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/consumer\_info\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html) .

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? [ Yes / No ]**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––*–––––––––––

Important Information Image

**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.

**About these Coverage Examples:**

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

|  |  |
| --- | --- |
| ◼ **The plan’s overall deductible** | **$1,000** |
| ◼ **Specialist Copayment** | **$30** |
| ◼ **Hospital (facility) Coinsurance** | **25%** |
| ◼ **Other No Charge** | **$0** |

**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** | **$12,800** |

**In this example, Peg would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $50 |
| Coinsurance | $2,000 |
| *What isn’t covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$3,150** |

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.floridablue.com](file:///C:\Users\f9ev\AppData\Local\Microsoft\Windows\INetCache\IE\Work_08_10\www.floridablue.com).

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

|  |  |
| --- | --- |
| ◼ **The plan’s overall deductible** | **$1,000** |
| ◼ **Specialist Copayment** | **$30** |
| ◼ **Hospital (facility) Coinsurance** | **25%** |
| ◼ **Other Coinsurance** | **25%** |

**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** | **$7,400** |

**In this example, Joe would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $6,000 |
| **The total Joe would pay is** | **$6,300** |

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

|  |  |
| --- | --- |
| ◼ **The plan’s overall deductible** | **$1,000** |
| ◼ **Specialist Copayment** | **$30** |
| ◼ **Hospital (facility) Coinsurance** | **25%** |
| ◼ **Other Copayment** | **$250** |

**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** | **$1,900** |

**In this example, Mia would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $600 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |



