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/plancontracts/group. 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/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000** Per Person/**$3,000** Family. Out-of-Network: Not Applicable.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$4,500** Per Person/**$9,000** Family. Out-Of-Network: Not Applicable.	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 1-800-352-2583 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 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.

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	Value Choice Provider: No Charge/ Primary Care Visits: $20 Copay per Visit/ Virtual Visits: No Charge	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $45 Copay per Visit/ Virtual Visits: $45 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: $25 Copay per Visit/ Independent Diagnostic Testing Center: $100 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Physician Office: $45 Copay per Visit/ Independent Diagnostic Testing Center: $250 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	Preventive: No Charge (retail)/ Condition Care Rx: $4 Copay per Prescription (retail)/ All Other Generic: $15 Copay per Prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 times the retail amount. Responsible Rx programs such as Prior Authorization may apply. Cost shares are for Preferred Pharmacies. Prescriptions filled at a Standard Pharmacy have higher cost share. See Medication guide for more information.
	Preferred brand drugs	Condition Care Rx: $30 Copay per Prescription (retail)/ All Other Preferred Brand: $60 Copay per Prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 times the retail amount. Cost shares are for Preferred Pharmacies. Prescriptions filled at a Standard Pharmacy have higher cost share.
	Non-preferred brand drugs	$100 Copay per Prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 times the retail amount. Cost shares are for Preferred Pharmacies. Prescriptions filled at a Standard Pharmacy have higher cost share.
	Specialty drugs	$200 Copay per Prescription (retail)	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $200 Copay per Visit/ Hospital: $350 Copay per Visit	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	$100 Copay per Visit	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$350 Copay per Visit	$350 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge - Visits 1-2 $50 Copay for remaining Visits/ Urgent	Not Covered	Out-of-Network only covered out-of-state.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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)	
		Care Visits: $50 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay per Day / $2,500 maximum	Not Covered	Inpatient Rehab Services limited to 30 days. Inpatient Habilitation Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	$100 Copay per Visit	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$45 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$100 Copay per Visit	Not Covered	————none————
	Childbirth/delivery facility services	$500 Copay per Day / $2,500 maximum	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$45 Copay per Visit	Not Covered	Coverage limited to 35 visits, including 35 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	$45 Copay per Visit	Not Covered	Coverage limited to 35 visits. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Skilled nursing care	Deductible + 20% Coinsurance	Not Covered	Coverage limited to 60 days. Prior Authorization may be required. Your

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)	
				benefits/services may be denied.
	Durable medical equipment	Motorized Wheelchairs: Deductible + 20% Coinsurance/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One exam per calendar year.
	Children's glasses	No Charge	Not Covered	One pair per calendar year. Additional cost shares may apply for Non-Collection Frame.
	Children's dental check-up	No Charge	Not Covered	Coverage includes preventive cleanings once per 6 months, and 1 set of bitewing x-rays.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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 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. 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 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 1-800-352-2583. 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. 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/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
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.*———————————

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	$1,000
Specialist Copayment	$45
Hospital (facility) Copayment	$500
Other Copayment	$25

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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	$45
Hospital (facility) Copayment	$500
Other No Charge	$0

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,930**

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

The plan's overall deductible	$1,000
Specialist Copayment	$45
Hospital (facility) Copayment	$500
Other Copayment	$350

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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.