

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

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



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 1-800-352-2583. In the event there is a conflict between this summary and your Florida Blue coverage documents the terms and conditions of the coverage documents will control.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall <u>deductible</u>? | In-Network: \$6,100 Per Person/ \$12,200 Family. Out-Of-Network: \$12,200 Per Person/ \$24,400 Family. Does not apply to In-Network preventive care. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. In-Network: \$6,850 Per Person/ \$13,700 Family. Out-Of-Network: \$12,500 Per Person/ \$25,000 Family. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>? | Premium, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network</u> of <u>providers</u>? | Yes. For a list of participating providers , see www.floridablue.com or call 1-800-352-2583. | 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 <u>specialist</u>? | No. | You can see the <u>specialist</u> 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 <u>excluded services</u> . |

Questions: Call 1-800-352-2583 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.floridablue.com or call 1-800-352-2583 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 | \$0 Copay - 1st Visit \$65 Copay for remaining Visits | Deductible + 50% Coinsurance | Physician administered drugs may have higher cost shares. |
| | Specialist visit | Deductible + \$90 Copay | Deductible + 50% Coinsurance | Physician administered drugs may have higher cost shares. |
| | Other practitioner office visit | Deductible + \$90 Copay | Deductible + 50% Coinsurance | Physician administered drugs may have higher cost shares. |
| | Preventive care/ screening/immunization | No Charge | 50% Coinsurance | Physician administered drugs may have higher cost shares. |
| If you have a test | Diagnostic test (x-ray, blood work) | Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: \$4 Copay | Independent Clinical Lab: Not Covered/ Independent Diagnostic Testing Center: Deductible + 50% Coinsurance | Tests performed in hospitals may have higher cost share. |
| | Imaging (CT/PET scans, MRIs) | Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | Prior authorization may be required. Tests performed in hospitals may have higher cost share. |
| If you need drugs to treat your illness or condition | Generic drugs | Generic 1 - No Charge (retail)/ Generic 2 - \$4 Copay per prescription (retail)/ Generic 3 - Deductible + \$30 Copay per prescription (retail) | Not Covered | Up to 30 day supply for retail. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information. Mail order is subject to approximately 2 1/2 times the retail amount. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|---|---|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| More information about prescription drug coverage is available at www.floridablue.com . | Preferred brand drugs | Brand 1 - \$23 Copay per prescription (retail)/ Brand 2 - Deductible + \$45 Copay per prescription (retail) | Not Covered | Up to 30 day supply for retail. Mail order is subject to approximately 2 1/2 times the retail amount. |
| | Non-preferred brand drugs | Non-preferred - Deductible + \$160 Copay per prescription (retail) | Not Covered | Up to 30 day supply for retail. Mail order is subject to approximately 2 1/2 times the retail amount. |
| | Specialty drugs | Deductible + \$200 Copay per prescription | Not Covered | Not covered through Mail Order. Up to 30 day supply for retail. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | —————none————— |
| | Physician/surgeon fees | No Charge | No Charge | —————none————— |
| If you need immediate medical attention | Emergency room services | Deductible + \$600 Copay | In-Network Deductible + \$600 Copay | —————none————— |
| | Emergency medical transportation | Deductible + 30% Coinsurance | In-Network Deductible + 30% Coinsurance | —————none————— |
| | Urgent care | Deductible + \$250 Copay | Deductible + 50% Coinsurance | —————none————— |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | Inpatient Rehab Services limited to 30 days. |
| | Physician/surgeon fee | No Charge | No Charge | —————none————— |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | Physician Office: Deductible + \$70 Copay/ Hospital: Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | Physician Services: No Charge/ Hospital: Deductible + 30% Coinsurance | Physician Services: No Charge/ Hospital: Deductible + 50% Coinsurance | —————none————— |
| | Substance use disorder outpatient services | Physician Office: Deductible + \$70 Copay/ Hospital: Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|---|--|---|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| | Substance use disorder inpatient services | Physician Services: No Charge/ Hospital: Deductible + 30% Coinsurance | Physician Services: No Charge/ Hospital: Deductible + 50% Coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | Deductible + \$90 Copay | Deductible + 50% Coinsurance | —————none————— |
| | Delivery and all inpatient services | Physician Services: No Charge/ Hospital: Deductible + 30% Coinsurance | Physician Services: No Charge/ Hospital: Deductible + 50% Coinsurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Coverage limited to 30 visits. |
| | Rehab services | Physician Office: Deductible + \$90 Copay/ Outpatient Rehab Center: Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | Coverage limited to 35 visits, including 35 manipulations. Services performed in hospitals may have a higher cost-share. |
| | Habilitation services | Physician Office: Deductible + \$90 Copay/ Outpatient Rehab Center: Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | Services performed in hospitals may have a higher cost-share. Included in coverage limitations for Rehabilitative Services. |
| | Skilled nursing care | Deductible + 30% Coinsurance | Deductible + 50% Coinsurance | Coverage limited to 60 days. |
| | Durable medical equipment | Motorized Wheelchairs: \$500 Copay/ All Other: No Charge | Not Covered | —————none————— |
| | Hospice service | No Charge | Deductible + 50% Coinsurance | —————none————— |
| If your child needs dental or eye care | Eye exam | No Charge | Not Covered | One exam per calendar year. |
| | Glasses | No Charge | Not Covered | One pair per calendar year. Additional cost shares may apply for Non-Collection Frame. |
| | Dental check-up | Not Covered | Not Covered | Not Covered |

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-expected abortions (i.e., not medically necessary)
- Pediatric dental check-up
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- 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.)

- Chiropractic care - Limited to 35 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:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-352-2583. You may also contact your state insurance department at 1-877-693-5236.

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, contact the insurer at 1-800-352-2583. You may also contact your state insurance department at 1-877-693-5236.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-352-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-352-2583.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-352-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-352-2583.

Plan Documents:

If you want more detail about coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-352-2583 or by clicking one of the links below:

[Purchased On-Marketplace](#)

http://www.bcbsfl.com/DocumentLibrary/COC/2016/IU65ACA/ONX/Plan_1443_ONEX_01JAN16.pdf

[Purchased Off-Marketplace](#)

http://www.bcbsfl.com/DocumentLibrary/COC/2016/IU65ACA/OFX/Plan_1443_OFFEX_01JAN16.pdf

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 \$1,150
- Patient pays \$6,390

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 | \$6,100 |
| Copays | \$90 |
| Coinsurance | \$0 |
| Limits or exclusions | \$200 |
| Total | \$6,390 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,120
- Patient pays \$1,280

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 | \$600 |
| Copays | \$600 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$1,280 |

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 the SBC 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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