BlueOptions 1418
Platinum

Coverage Period: 01/01/2017 - 12/31/2017

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/plancontracts/individual 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 deductible?	In-Network: **$800** Per Person/**$1,600** Family. Out-Of-Network: **$2,400** Per Person/**$4,800** Family. Does not apply to In-Network 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$2,500** Per Person/**$5,000** Family. Out-Of-Network: **$5,400** Per Person/**$10,800** Family.	The **out-of-pocket limit** 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 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**.
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. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of **network providers**.	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 5. See your policy or plan document for additional information about **excluded services**.

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/plancontracts/individual 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 - Visits 1-3 $15 Copay for remaining Visits	Deductible + 50% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	$20 Copay	Deductible + 50% Coinsurance	Physician administered drugs may have higher cost shares.
	Other practitioner office visit	$20 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: Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% 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	Preventive: No Charge (retail)/ Condition Care Rx: $4 Copay per prescription (retail)/ All Other Generic: $10 Copay per prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 ½ times the retail amount. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.

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/tools-resources/pharmacy/medication-guide.	Preferred brand drugs	Condition Care Rx: $20 Copay per prescription (retail)/ All Other Preferred Brand: $40 Copay per prescription (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 ½ times the retail amount.
	Non-preferred brand drugs	30% Coinsurance (retail)	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order at 2 ½ times the retail amount.
	Specialty drugs	50% Coinsurance (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)	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	No Charge	No Charge	————none————
If you need immediate medical attention	Emergency room services	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	$50 Copay	Deductible + $50 Copay	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days. Inpatient Habilitation 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: $20 Copay/ Outpatient Hospital: Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	————none————
	Mental/Behavioral health inpatient services	Physician Services: No Charge/ Inpatient Hospital: Deductible + 10% Coinsurance	Physician Services: No Charge/ Hospital: 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 outpatient services	Physician Office: $20 Copay/ Outpatient Hospital: Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Option 2 hospitals may have higher cost shares.
	Substance use disorder inpatient services	Physician Services: No Charge/ Inpatient Hospital: Deductible + 10% Coinsurance	Physician Services: No Charge/ Inpatient Hospital: Deductible + 50% Coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	$20 Copay	Deductible + 50% Coinsurance	————none————
	Delivery and all inpatient services	Physician Services: No Charge/ Hospital: Deductible + 10% 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	Deductible + 50% Coinsurance	Coverage limited to 30 visits.
	Rehab services	Physician Office: $20 Copay/ Outpatient Rehab Center: Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 35 manipulations. Services performed in hospital may have higher cost share.
	Habilitation services	$20 Copay	Deductible + 50% Coinsurance	Services performed in hospital may have higher cost share. Coverage limited to 35 visits.
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Motorized Wheelchairs: $500 Copay/ All Other: No Charge	Deductible + 50% Coinsurance	————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-excepted 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 <u>does provide</u> 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, kwiijigo holne' **1-800-352-2583**.

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** $6,200
- **Patient pays** $1,340

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	$800
Copays	$40
Coinsurance	$300
Limits or exclusions	$200
Total	**$1,340**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,220
- **Patient pays** $180

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	$0
Copays	$100
Coinsurance	$0
Limits or exclusions	$80
Total	**$180**

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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Nondiscrimination and Accessibility Notice (ACA §1557)

Florida Blue and Florida Blue HMO comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Blue and Florida Blue HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue and Florida Blue HMO:

- Provides 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)
    - Provides 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 1-800-352-2583.

If you believe that Florida Blue and Florida Blue HMO has 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: Senior Manager of Business Ethics at 4800 Deerwood Campus Parkway, DC1-7, Jacksonville, FL 32246, by phone at 1-800-477-3736 X56300 (TTY:1-800-955-8770), by fax at 904-357-8203, or email compass@floridablue.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Senior Manager of Business Ethics 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,* or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1–800–868–1019, 800–537–7697 (TDD).

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

Have a disability? Speak a language other than English? Call to get help for free. [1-800-352-2583] (TTY: 1-800-955-8770)

¿Habla español? ¿Tiene alguna discapacidad? Llame para obtener ayuda de forma gratuita al [1-800-352-2583] (TTY: 1-800-955-8773)

Èske w pale kreyòl ayisyen? Èske w andikape? Rele nou pou w jwenn èd graris. [1-800-352-2583] (pou moun ki tande di: 1-800-955-8770)

Quý vị nói tiếng Việt? Quý vị bị khuyết tật? Hãy gọi trợ giúp miễn phí. [1-800-352-2583] (TTY: 1-800-955-8770)

Você fala potuguês? Tem alguma deficiência? Telefone para obter assistência. [1-800-352-2583] (TTY: 1-800-955-8770)

您会讲中文吗？是否为伤残人士？如需帮助，请拨打我们的免费电话：[1-800-352-2583]（TTY：1-800-955-8770）

Vous parlez français ? Vous avez une incapacité ? Appelez pour recevoir une assistance gratuite. [1-800-352-2583] (TTY: 1-800-955-8770)

Nagsasalita ng Tagalog o Filipino? May kapansanan? Tumawag para sa libreng tulong. [1-800-352-2583] (TTY: 1-800-955-8770)

Вы говорите по-русски? Вы являетесь инвалидом? Свяжитесь с нами для получения бесплатной помощи по телефону [1-800-352-2583] (телетайп: 1-800-955-8770)

هل تتحدث (العربية)؟ هل لديك إعاقة؟ اتصل للحصول على مساعدة مجانية. [1-800-352-2583] (التواصل للذين يعانون من مشاكل في السمع: 1-800-955-8770)

Parli italiano? Hai una disabilità? Chiama per un'assistenza gratuita. [1-800-352-2583]
(TTY: 1-800-955-8770)

Sprechen Sie deutsch? Haben Sie eine Behinderung? Rufen Sie an, um kostenlos Hilfe zu erhalten. [1-800-352-2583] (TTY: 1-800-955-8770)

한국어 통역이 필요하세요? 장애가 있나요? 전화하시면 무료로 도와드립니다. [1-800-352-2583] (TTY: 1-800-955-8770)

Mówi po polsku? Czy ma niepełnosprawność? Zadzwoń po bezpłatną pomoc. [1-800-352-2583] (TTY: 1-800-955-8770)

ગુજરાતી બોલો છો? અક્ષમતા ધરાવો છો? મફત સહાયતા મેળવવા ફોન કરો. [1-800-352-2583] (TTY: 1-800-955-8770)

พูดภาษาไทยได้? เป็นผู้พิการใช่หรือไม่? โทรศัพท์ขอรับคำปรึกษาได้ฟรีที่ [1-800-352-2583] (หมายเลขโทรศัพท์สำหรับผู้พิการทางการได้ยิน: 1-800-955-8770)