**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/individual. 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/individual or call 1-855-692-5830 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$940** Per Person/**$1,880** 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?** | In-Network: **$4,700** Per Person/**$9,400** 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 1-855-692-5830 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?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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, Deductible does not apply/ Primary Care Visits: $90 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply | 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: $120 Copay per Visit/ Virtual Visits: $120 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, Deductible does not apply | 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) | Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance | 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) | Value Choice Provider: $20 Copay per Visit/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance | 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, Deductible does not apply (retail/mail order)/ Condition Care Rx: $4 Copay per Prescription (retail)/ Low Cost Generic: $15 Copay per Prescription (retail)/ High Cost Generic: Deductible + 15% Coinsurance (retail/mail order) | Not Covered | Up to 30 day supply for retail, 90 day supply for mail order at 2 1/2 times the retail amount. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information. |
| | Preferred brand drugs | Condition Care Rx: $30 Copay per Prescription (retail)/ All Other Preferred Brand: Deductible + 15% Coinsurance (retail/mail order) | Not Covered | Up to 30 day supply for retail, 90 day supply for mail order at 2 1/2 times the retail amount. |
| | Non-preferred brand drugs | Deductible + 50% Coinsurance (retail/mail order) | Not Covered | Up to 30 day supply for retail, 90 day supply for mail order at 2 1/2 times the retail amount. |
| | Specialty drugs | Deductible + 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 + 20% Coinsurance | Not Covered | Prior Authorization may be required. Your benefits/services may be denied. |
| | Physician/surgeon fees | Deductible + 20% Coinsurance | Not Covered | ————none———— |
| **If you need immediate medical attention** | Emergency room care | Deductible + 20% Coinsurance | In-Network Deductible + 20% Coinsurance | ————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, Deductible does not apply - Visits 1-2;$120 Copay per remaining Visit/ Urgent Care Visits: $120 Copay per Visit | Not Covered | Out-of-Network only covered out-of-state. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible + 20% Coinsurance | Not Covered | Inpatient Rehab Services limited to 30 days. Inpatient Habilitation Services limited to 30 |

| 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) | |
| | | | | days. Prior Authorization may be required. Your benefits/services may be denied. |
| | Physician/surgeon fees | Deductible + 20% Coinsurance | Not Covered | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Specialist Virtual Visits: No Charge, Deductible does not apply/ Physician Office: $55 Copay per Visit / Hospital: Deductible + 20% Coinsurance | 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 | Deductible + 20% Coinsurance | Not Covered | Prior Authorization may be required. Your benefits/services may be denied. |
| **If you are pregnant** | Office visits | $120 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 | Deductible + 20% Coinsurance | Not Covered | ————none———— |
| | Childbirth/delivery facility services | Deductible + 20% Coinsurance | Not Covered | ————none———— |
| **If you need help recovering or have other special health needs** | Home health care | No Charge, Deductible does not apply | Not Covered | Coverage limited to 60 visits. |
| | Rehabilitation services | $120 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 | $120 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 benefits/services may be denied. |
| | Durable medical equipment | Motorized Wheelchairs: $500 | Not Covered | Excludes vehicle modifications, home |

| 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) | |
| | | Copay/ All Other: No Charge, Deductible does not apply | | 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 | No Charge, Deductible does not apply | 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, Deductible does not apply | Not Covered | One exam every 12 months. |
| | Children's glasses | No Charge, Deductible does not apply | Not Covered | One pair every 12 months. Additional cost shares may apply for Non-Collection Frame. |
| | 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-excepted abortions (i.e., not medically necessary)
- Pediatric dental check-up
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless medically necessary
- 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.

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, State consumer assistance program www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/, Office of Personnel Management Multi State Plan Program: www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. Or Healthcare.gov www.HealthCare.gov or call 1-800-318-2596 OR state health insurance marketplace or SHOP. 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. 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? Not Applicable**
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** | **$940** |
| **Specialist Copayment** | **$120** |
| **Hospital (facility) Coinsurance** | **20%** |
| **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** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $100 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,560** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$940** |
| **Specialist Copayment** | **$120** |
| **Hospital (facility) Coinsurance** | **20%** |
| **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 | $900 |
| Copayments | $1,300 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,620** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$940** |
| **Specialist Copayment** | **$120** |
| **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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

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.

## Section 1557 Notification: Discrimination is Against the Law

We 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.

We 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- 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 discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

**Health and vision coverage (including FEP members):**
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

**Dental, life, and disability coverage:**
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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.