**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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not Applicable. | This plan does not have a deductible. |
| **Are there other deductibles for specific services?** | Yes. **$2,500** Pharmacy Deductible; . There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: **$12,000** Per Person/**$24,000** 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 1-855-692-5830 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/ Primary Care Visits: $35 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 | Specialist: $105 Copay per Visit/ Virtual Visits: $105 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) | Independent Clinical Lab: $45 Copay per Visit/ Independent Diagnostic Testing Center: $175 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) | $400 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 | Tier 1: Zero-Cost | No Charge (retail/home delivery) | Not Covered | Up to 30-day supply for retail, 90-day supply for retail and home delivery is limited to Generic drugs only.<br><br>Home delivery at 2 1/2 times the retail amount may be available. Specialty Drugs not covered through home delivery. Refer to Medication Guide for more information.<br><br>Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.<br><br>Generic, Brand and Specialty drugs may be available on multiple tiers and subject to that tier's applicable cost share. Refer to the Medication Guide for details about specific drugs and their costs. |
| | Tier 2: Lowest-Cost | $20 Copay per Prescription (retail) | Not Covered | |
| | Tier 3: Low-Cost | $35 Copay per Prescription (retail) | Not Covered | |
| | Tier 4: Mid-Range-Cost | $2,500 Pharmacy Deductible + $50 Copay per Prescription (retail) | Not Covered | |
| | Tier 5: High-Cost | $2,500 Pharmacy Deductible + $350 Copay per Prescription (retail) | Not Covered | |
| | Tier 6: Highest-Cost | $2,500 Pharmacy Deductible + 50% Coinsurance (retail/home delivery) | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center: $1,500 Copay per Visit/ Hospital: $1,600 Copay per Visit | Not Covered | Prior Authorization may be required. Your benefits/services may be denied. |
| | Physician/surgeon fees | $300 Copay per Visit | Not Covered | ————none———— |
| **If you need immediate medical attention** | Emergency room care | Physician Services: $300 Copay per Visit/ Facility: $1,500 Copay per Visit | Physician Services: $300 Copay per Visit/ Facility: $1,500 Copay per Visit | ————none———— |
| | Emergency medical transportation | 50% Coinsurance | 50% Coinsurance | Out-of-Network only covered for emergencies. |
| | Urgent care | Value Choice Provider: No Charge - Visits 1-2;$50 Copay per remaining Visit/ Urgent Care Visits: $50 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) | $3,400 Copay per Day / $6,800 maximum | 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 | $300 Copay per Visit | Not Covered | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Physician Office: $105 Copay per Visit/ Hospital: $1,600 Copay per Visit/ 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 | Physician Services: $300 Copay per Visit / Hospital: $3,400 Copay per Day / $6,800 maximum | Not Covered | Prior Authorization may be required. Your benefits/services may be denied. |
| **If you are pregnant** | Office visits | $105 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 | $300 Copay per Visit | Not Covered | ————none———— |
| | Childbirth/delivery facility services | $3,400 Copay per Day / $6,800 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 | $105 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 | $105 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 | 50% 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 Copay/ All Other: No Charge | Not Covered | Excludes vehicle modifications, home modifications, exercise, bathroom equipment |

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

| 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) | |
| | | | | and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied. |
| | Hospice services | No Charge | 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 every 12 months. |
| | Children's glasses | No Charge | Not Covered | One pair every 12 months. Additional out-of-pocket costs above the standard allowance for frames and lenses will not be applied to the Maximum Out-of-Pocket (MOOP). Please refer to your plan policy documents for more details. |
| | 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** | **$0** |
| **Specialist Copayment** | **$105** |
| **Hospital (facility) Copayment** | **$3,400** |
| **Other Copayment** | **$45** |

**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 | $4,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,060** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist Copayment** | **$105** |
| **Hospital (facility) Copayment** | **$3,400** |
| **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* | $2,500 |
| Copayments | $2,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,900** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist Copayment** | **$105** |
| **Hospital (facility) Copayment** | **$3,400** |
| **Other Copayment** | **$1,500** |

**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 | $0 |
| Copayments | $1,100 |
| Coinsurance | $500 |
| *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.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

# 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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Postal Employee Program (PEP): 1-844-960-2583
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

**Health and vision coverage (including FEP and PEP 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@bcbsfl.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

87768 0825R

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator or Civil Rights 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, or 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 www.hhs.gov/ocr/office/file/index.html

Visit www.floridablue.com/disclaimer/ndnotice to view an electronic version of this notice.

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-800-352-2583, a FEP al 1-800-333-2227, a PEP al 1-844-960-2583, a Medicare al 1-800-926-6565, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòma ki disponib gratis. Rele nan 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, oswa rele Medicare nan 1-800-926-6565 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-800-352-2583 联邦雇员计划（ FEP）1-800-333-2227 医疗保险（Medicare）1-800-926-6565 听障专线（TTY）711。联邦雇员计划 (FEP) 1-800-333-2227

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-800-352-2583, le FEP au 1-800-333-2227, le PEP au 1-844-960-2583, le Medicare au 1-800-926-6565 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (номер для текст-телефонных устройств (TTY) 711).

:الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على
Medicare: 1-800-926-6565 (لذوي الإعاقة السمعية TTY: 711) 1-800-352-2583 برنامج FEP: 1-800-333-2227 برنامج PEP: 1-844-960-2583 برنامج

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-800-352-2583, FEP: 1-800-333-2227, PEP: 1-844-960-2583, Medicare: 1-800-926-6565, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583,메디케어 1-800-926-6565, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફૉર્મેટ સેવાઓ ઉપલબ્ધ છે.
1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565, (TTY 711) પર કૉલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-800-352-2583, FEP 1-800-333-2227, PEP 1-844-960-2583, Medicare 1-800-926-6565 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-800-352-2583、FEP 1-800-333-2227、PEP 1-844-960-2583、メディケア 1-800-926-6565 (TTY 711) までお電話ください。

با 1-800-333- FEP خدمات رایگان زبانی، کمکهای جانبی، و قالبهای جایگزین در دسترس هستند. با شماره 1-800-352-2583 تماس بگیرید. برای تماس بگیرید (TTY: 711) با 1-800-926-6565 Medicare و برای 2227

T’áá free yiníłta’go saad bee áká anilyeedígíí, ałk’ida’áníígíí, dóó t’áá ajiłii hane’ bee áká anilyeedígíí t’éiyá éí hołne’. 1-800-352-2583 bich’į’ náhodoonih, FEP bich’į’ 1-800-333-2227 bich’į’ náhodoonih, PEP bich’i’ 1-844-960-2583 bich’į’ náhodoonih, Medicare bich’į’ 1-800-926-6565 bich’į’ náhodoonih, (TTY 711).