



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> ?	\$3,000 in-network family/ \$6,000 out-of-network 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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,000 in-network family/ \$12,000 out-of-network 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 <u>out-of-pocket limit</u> ?	Premiums, 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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of 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 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 .

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

Coverage for: Family | **Plan Type:** PPO



- **Copayments** 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs.
	Specialist visit	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	
	Other practitioner office visit	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	
	Preventive care/ screening/immunization	\$0	40% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + \$0 for Independent Clinical Lab; Deductible + 10% Coinsurance for Independent Diagnostic Testing Center and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Independent Clinical Lab, Independent Diagnostic Testing Center and Outpatient Hospital Facility	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility	

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

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com	Generic drugs	Deductible + \$10 Copayment per prescription (Retail); Deductible + \$25 Copayment per prescription (Mail order)	In-network Deductible + 50% Coinsurance	Covers up to 30-day supply (retail prescription); 90-day supply (mail order prescription). Responsible Rx programs such as Prior Authorization, Responsible Steps or Responsible Quantity may apply. Additional information can be found in the Medication Guide.
	Preferred brand drugs	Deductible+ \$50 Copayment per prescription (Retail); Deductible + \$125 Copayment per prescription (Mail order)	In-network Deductible + 50% Coinsurance	
	Non-preferred brand drugs	Deductible+ \$80 Copayment per prescription (Retail); Deductible + \$200 Copayment per prescription (Mail order)	In-network Deductible + 50% Coinsurance	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on applicable drug tier.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance for Ambulatory Surgery Center and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Ambulatory Surgery Center and Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-network Deductible + 10% Coinsurance	None
If you need immediate medical attention	Emergency room services	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	None
	Emergency medical transportation	Deductible + 10% Coinsurance	In-network Deductible + 10% Coinsurance	Coverage is limited to \$5,500 per day.
	Urgent care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Inpatient Rehabilitation Services are limited to 21 days per benefit period.
	Physician/surgeon fee	Deductible + 10% Coinsurance	In-network Deductible + 10% Coinsurance	None

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage is limited to 20 visits per benefit period. Prior authorization may be required.
	Mental/Behavioral health inpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage is limited to 30 days per benefit period.
	Substance use disorder outpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Prior authorization may be required.
	Substance use disorder inpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
If you are pregnant	Prenatal and postnatal care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
	Delivery and all inpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage is limited to 20 visits per benefit period.
	Rehabilitation services	Deductible + 10% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Coverage is limited to 35 visits per benefit period.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage is limited to 60 days per benefit period.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
	Hospice service	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	None

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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 Services | • Hearing Aids | • Infertility treatments |
| • Long-term care | • Private-duty nursing | • Routine eye care (Adults) |
| • Routine foot care except 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 | • Non-emergency care when traveling outside the U.S. | • Most coverage provided outside the United States. See www.bcbs.com/already-a-member/coverage-home-and-away.html |
|---------------------|--|--|

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-352-2583. You may also contact your state insurance department at **1-877-693-5236**, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

For more information on your rights to a **grievance** or **appeal**, contact the insurer at 1-800-352-2583. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, state insurance department at 1-877-693-5236.

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.

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, kwiiijigo holne' 1-800-352-2583.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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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 \$3,920
- Patient pays \$3,620

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,000
Copays	\$20
Coinsurance	\$400
Limits or exclusions	\$200
Total	\$3,620

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

- Amount owed to providers: \$5,400
- Plan pays \$2,600
- Patient pays \$2,800

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,000
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$400
Total	\$2,800

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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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, 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 copayments, 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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