

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services


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



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.\[insert\].com](http://www.[insert].com). 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.\[insert\].com](http://www.[insert].com) or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$2,000 Per Person. Out-of-Network: \$6,000 Per Person.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Yes. In-Network: \$6,350 Per Person/ \$12,700 Family. Out-Of-Network: \$30,000 Per Person/ \$30,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	\$75 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: \$50 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	\$200 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tols-resources/pharmacy/medication-guide	Generic drugs	\$15 <u>Copay</u> per Prescription at retail, \$40 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	\$50 <u>Copay</u> per Prescription at retail, \$125 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	\$80 <u>Copay</u> per Prescription at retail, \$200 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are	<u>Specialty drugs</u> are subject	Not covered through Mail Order. Up to 30 day

For more information about limitations and exceptions, see the plan or policy document at [www.\[insert\].com](http://www.[insert].com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
		subject to the cost share based on applicable drug tier.	to the cost share based on the applicable drug tier.	supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital Option 1: \$300 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 50% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: <u>In-Network Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
	<u>Urgent care</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: \$2,000 <u>Copay</u> per Admission	<u>Deductible</u> + 50% <u>Coinsurance</u>	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 50% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	50% <u>Coinsurance</u>	—————none—————
	Inpatient services	No Charge	Physician Services: No Charge/ Hospital: 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$75 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional	<u>Deductible</u> + 50%	<u>In-Network Deductible</u> +	—————none—————

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