**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.725benefits.org. 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.healthcare.gov/sbc-glossary or call 1-800-352-2583 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$500** Per Person/**$1,500** Family. Out-of-Network: Combined with In-Network. | 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?** | Yes. **$300** Out-of-Network Per Admission Deductible; **$300** In-Network/ **$300** Out-of-Network Per ER Visit. 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?** | Yes. In-Network: **$4,500** Per Person/**$9,000** 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 1-800-352-2583 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | Primary Care Visits: $45 Copay per Visit/<br><br>Virtual Visits (Telemedicine): $45 Copay per Visit/ | Primary Care Visits: Deductible + 40% Coinsurance/<br><br>Virtual Visits (Telemedicine): Not Covered/ | ————none———— |
| | Specialist visit | Specialist: Deductible + 20% Coinsurance /<br><br>Virtual Visits (Telemedicine): Deductible + 20% Coinsurance / | Specialist: Deductible + 40% Coinsurance /<br><br>Virtual Visits (Telemedicine): Not Covered/ | ————none———— |
| | Preventive care/screening/ immunization | No Charge | 40% Coinsurance | ————none———— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Independent Clinical Lab: 20% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance | Independent Clinical Lab: 40% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 40% Coinsurance | Prior authorization may be required for certain procedures. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. |
| | Imaging (CT/PET scans, MRIs) | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | Prior Authorization may be required. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. |

| 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 www.floridablue.com/tools-resources/pharmacy/medication-guide | Generic drugs | $15 Copay per Prescription at retail, $30 Copay per Prescription by mail | 50% Coinsurance | Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information. |
| | Preferred brand drugs | $35 Copay per Prescription at retail, $70 Copay per Prescription by mail | 50% Coinsurance | |
| | Non-preferred brand drugs | $65 Copay per Prescription at retail, $130 Copay per Prescription by mail | 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 the applicable drug tier. | Not covered through Mail Order. Up to 30 day supply for retail. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | ————none———— |
| | Physician/surgeon fees | Deductible + 20% Coinsurance | Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: Deductible + 20% Coinsurance | ————none———— |
| **If you need immediate medical attention** | Emergency room care | Per Visit Deductible + 20% Coinsurance | Per Visit Deductible + 20% Coinsurance | ————none———— |
| | Emergency medical transportation | Deductible + 20% Coinsurance | Deductible + 20% Coinsurance | ————none———— |
| | Urgent care | $45 Copay per Visit | Deductible + 40% Coinsurance | ————none———— |

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | Deductible + 20% Coinsurance | Per Admission Deductible + Deductible + 40% Coinsurance | Prior Authorization may be required. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. |
| | Physician/surgeon fees | Deductible + 20% Coinsurance | Deductible + 20% Coinsurance | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Covered | Not Covered | ————none———— |
| | Inpatient services | Not Covered | Not Covered | Prior Authorization may be required. Your benefits/services may be denied. |
| **If you are pregnant** | Office visits | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | Deductible + 20% Coinsurance | Deductible + 20% Coinsurance | ————none———— |
| | Childbirth/delivery facility services | Deductible + 20% Coinsurance | Per Admission Deductible + Deductible + 40% Coinsurance | ————none———— |
| **If you need help recovering or have other special health needs** | Home health care | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | ————none———— |
| | Rehabilitation services | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | Occupational Therapy is Not Covered. |
| | Habilitation services | Not Covered | Not Covered | Not Covered |
| | Skilled nursing care | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | Coverage limited to 60 days. |
| | Durable medical equipment | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DMEdue to use/age. |
| | Hospice services | Deductible + 20% Coinsurance | Deductible + 40% Coinsurance | ————none———— |

| 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 your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered |
| | Children's glasses | Not Covered | Not Covered | Not Covered |
| | Children's dental check-up | No Charge | 0% Coinsurance plus amounts over allowed charges | Coverage is through Florida Combined Life and is limited to 2 visits and $2,500 in any Contract Year |

**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
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Mental health/behavioral health and substance abuse services
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- 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
- Dental care (Adult/Child) through Florida Combined Life.
- Most coverage provided outside the United States. See www.floridablue.com.
- For any questions regarding dental benefits, or if you desire to appeal a denial of coverage of any dental claim, please contact Florida Combined Life at **1-888-223-4892** or visit its website at **www.floridabluedental.com**.
- Non-emergency care when traveling outside the U.S.

**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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1 -877-267-2323 x61565 or www.cciio.cms.gov. 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 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may

For more information about limitations and exceptions, see the plan or policy document at **www.725benefits.org**.

also contact the state insurance department 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/consumer_info_health.html .

**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 Minimum Value Standards? Yes**
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 | $500 |
| Specialist Coinsurance | 20% |
| Hospital (facility) Coinsurance | 20% |
| Other Coinsurance | 20% |

**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 | $500 |
| Copayments | $40 |
| Coinsurance | $2,420 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,020** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist Coinsurance | 20% |
| Hospital (facility) Coinsurance | 20% |
| Other Coinsurance | 20% |

**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 | $500 |
| Copayments | $1,900 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$2,510** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist Coinsurance | 20% |
| 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* | $700 |
| Copayments | $0 |
| Coinsurance | $420 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,120** |

*Includes Per Visit Deductible

The plan would be responsible for the other costs of these EXAMPLE covered services.