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/group. 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/group or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person/**$4,500** 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?	Yes. **$100** 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?	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 1-800-664-5295 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?	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	$30 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	$55 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost shares. 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/ Independent Diagnostic Testing Center: $50 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)	$250 Copay per Visit	Not Covered	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 **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	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	$100 Pharmacy Deductible + $30 Copay per Prescription at retail, $100 Pharmacy Deductible + $75 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$100 Pharmacy Deductible + $50 Copay per Prescription at retail,	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.

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)	
		$100 Pharmacy Deductible + $125 Copay per Prescription by mail		
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $200 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Ambulatory Surgical Center: $55 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$250 Copay per Visit	$250 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	$60 Copay per Visit	Not Covered	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 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	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$55 Copay per Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e.

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

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)	
				ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% Coinsurance	Not Covered	Option 2 hospitals may have a higher cost-share.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 20 visits.
	Rehabilitation services	$55 Copay per Visit	Not Covered	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	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 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home 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	Deductible + 20% Coinsurance	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	Covered	Not Covered	Coverage limited to one per calendar year.
	Children's glasses	Covered	Not Covered	Coverage limited to $150 every 24 months.
	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	• Hearing aids	• Pediatric dental check-up
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care unless for treatment of diabetes
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Habilitation services		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Pediatric eye exam	• Routine eye care (Adult)
• Most coverage provided outside the United States. See www.floridablue.com.	• Pediatric glasses	

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 1-800-664-5295. 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 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

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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	$1,500
Specialist Copayment	$55
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,590**

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

The plan's overall deductible	$1,500
Specialist Copayment	$55
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$100
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	20%
Other Copayment	$250

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Mia would pay is	**$1,700**

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.

Nondiscrimination and Accessibility Notice (ACA §1557)

Florida Blue and Florida Blue HMO comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Blue and Florida Blue HMO comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Blue and Florida Blue HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue and Florida Blue HMO:

- Provides 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)
    - Provides 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 1-800-664-5295.

If you believe that Florida Blue and Florida Blue HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Senior Manager of Business Ethics at 4800 Deerwood Campus Parkway, DC1-7, Jacksonville, FL 32246, by phone at 1-800-477-3736 X56300 (TTY:1-800-955-8770), by fax at 904-357-8203, or email compass@floridablue.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Senior Manager of Business Ethics 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, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Have a disability? Speak a language other than English? Call to get help for free. [1-800-664-5295] (TTY: 1-800-955-8770)

¿Habla español? ¿Tiene alguna discapacidad? Llame para obtener ayuda de forma gratuita al [1-800-664-5295] (TTY: 1-800-955-8773)

Èske w pale kreyòl ayisyen? Èske w andikape? Rele nou pou w jwenn èd graris. [1-800-664-5295] (pou moun ki tande di: 1-800-955-8770)

Quý vị nói tiếng Việt? Quý vị bị khuyết tật? Hãy gọi trợ giúp miễn phí. [1-800-664-5295] (TTY: 1-800-955-8770)

Você fala potuguês? Tem alguma deficiência? Telefone para obter assistência. [1-800-664-5295] (TTY: 1-800-955-8770)

您会讲中文吗？是否为伤残人士？如需帮助，请拨打我们的免费电话：[1-800-664-5295]（TTY：1-800-955-8770）

Vous parlez français ? Vous avez une incapacité ? Appelez pour recevoir une assistance gratuite. [1-800-664-5295] (TTY: 1-800-955-8770)

Nagsasalita ng Tagalog o Filipino? May kapansanan? Tumawag para sa libreng tulong. [1-800-664-5295] (TTY: 1-800-955-8770)

Вы говорите по-русски? Вы являетесь инвалидом? Свяжитесь с нами для получения бесплатной помощи по телефону [1-800-664-5295] (телетайп: 1-800-955-8770)

هل تتحدث (العربية)؟ هل لديك إعاقة؟ اتصل للحصول على مساعدة مجانية. [1-800-664-5295] (التواصل للذين يعانون من مشاكل في السمع: 1-800-955-8770)

Parli italiano? Hai una disabilità? Chiama per un'assistenza gratuita. [1-800-664-5295] (TTY: 1-800-955-8770)

Sprechen Sie deutsch? Haben Sie eine Behinderung? Rufen Sie an, um kostenlos Hilfe zu erhalten. [1-800-664-5295] (TTY: 1-800-955-8770)

한국어 통역이 필요하세요? 장애가 있나요? 전화하시면 무료로 도와드립니다. [1-800-664-5295] (TTY: 1-800-955-8770)

Mówi po polsku? Czy ma niepełnosprawność? Zadzwoń po bezpłatną pomoc. [1-800-664-5295] (TTY: 1-800-955-8770)

ગુજરાતી બોલો છો? અક્ષમતા ધરાવો છો? મફત સહાયતા મેળવવા ફોન કરો. [1-800-664-5295] (TTY: 1-800-955-8770)

พูดภาษาไทยได้? เป็นผู้พิการใช่หรือไม่? โทรศัพท์ขอรับคำปรึกษาได้ฟรีที่ [1-800-664-5295] (หมายเลขโทรศัพท์สำหรับผู้พิการทางการได้ยิน: 1-800-955-8770)

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-664-5295 (TTY: 1-800-955-8770). FEPígíí éí kojį' hodíílnih 1-800-333-2227