GIDDENS SECURITY CORP 2024

Plan Name:	05907 BlueOptions	05302 BlueOptions	03900 BlueOptions	52 BlueCare HMO
Carrier:	Florida Blue - Large Group	Florida Blue - Large Group	Florida Blue - Large Group	Florida Blue - Large Group
PLAN FEATURES				
Deductible Ind / Fam	$7,500 / $15,000	$5,000 / $10,000	$1,500 / N/A	$1,500 Per Person
Coinsurance	20%	30%	50%	30%
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	$8,200 / $16,400	$6,350 / $12,700	$6,350 / $13,300	$6,350 / $12,700
Wellness / Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
PHYSICIAN SERVICES				
PCP Office Copay	$0 COPAY up to 3 visits then $30 Copay	$30 Copay	$35 Copay	$40 Copay
Specialist Office Copay	Specialist: $60 Copay	$55 Copay	$50 Copay	$65 Copay
HOSPITAL CARE				
Inpatient Hospital Facility Fee	20% after DED	30% after DED	Option 1: $1,500 Copay; Option 2: $2,500 Copay	30% after DED
Outpatient Diagnostic Testing	Lab: $0 Copay; X-Ray: $60 Copay; Advanced Imaging: 20% after DED	Lab: $0 Copay; X-Ray & Advanced Imaging: 30% after DED	Lab: $0 Copay; X-Ray: 50% after DED; Advanced Imaging: $200 Copay	Lab: $0 Copay; X-Ray: $65 Copay; Advanced Imaging: $300 Copay
Outpatient Surgery Facility Fee	20% after DED	30% after DED	Option 1: $300 Copay;	30% after DED
EMERGENCY MEDICAL CARE				
Emergency Room Facility Fee Emergency Medical Transportation	20% after DED	$300 Copay 30% after DED	50% after DED	$300 Copay 30% after DED
Urgent Care Facility Fee	$100 Copay	$60 Copay	50% after DED	$85 Copay
Referrals	Not Required	Not Required	Not Required	Not Required
PHARMACY - PRESCRIPTION DRUG BENEFIT				
Deductible	N/A	N/A	N/A	N/A
Prescription Drug Benefit	Generic: $10 Copay	Generic: $10 Copay	Generic: $10 Copay	Generic: $10 Copay
	Preferred Brands: 20% up to a max of $200 per prescription	Preferred Brands: 20% up to a max of $200 per prescription	Preferred Brands: 20% up to a max of $200 per prescription	Brand: $30 Copay
	Non-Preferred: Not Covered	Non-Preferred: Not Covered	Non-Preferred: Not Covered	Non-Preferred: $50 Copay
OUT-OF-NETWORK PROVISIONS				
Deductible Ind / Fam	$15,000 / $30,000	$10,000 / $30,000	$4,500 / N/A	Not Covered
Coinsurance	50%	50%	50%	Not Covered
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	$16,400 / $32,800	$20,000 / $40,000	$20,000 / $20,000	Not Covered

This is only a summary. Please ask your employer If you want more detail about your coverage and costs, or you can get the complete terms in the policy or plan document at the carrier website. In the event there is a conflict between this summary and your carrier coverage documents, the terms and conditions of the coverage documents will control.

Member Tier	Employee Bi-Weekly Rates			
Employee Only	$60.39	$90.50	$89.87	$148.95
Employee + Spouse	$496.14	$564.76	$563.37	$700.07
Employee + Child	$400.82	$461.04	$459.79	$579.70
Family	$809.35	$905.69	$903.69	$1,095.56

Florida Blue | truli for health A Florida Blue Affiliate

Employee Enrollment Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name: | Group #: | Division #: | Package #:

Effective Date of Coverage: | Date of Hire: | Location #: | Employee #: | Job Title:

Work Status: ☐ Actively at Work ☐ Cobra ☐ Retired Retirement Date: | Paid: ☐ Hourly ☐ Salary ☐ Open Enrollment

Section B: Employee Information

Social Security #: | Last Name: | First Name: | M.I.: | Birth Date: | Sex: ☐ M ☐ F

Street Address: | Apt. #: | City: | State: | Zip:

County: | Phone: | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Physician Name / ID # *HMO only:* | Existing Patient: ☐ Yes ☐ No | Language of Preference: *optional - for data collection purposes only* ☐ English ☐ Spanish ☐ Other _____ ☐ Prefer not to answer

Ethnicity *optional* *Check all that apply:* ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caribbean Islander ☐ Hispanic ☐ Native American ☐ White

Section C: Health Coverage Level and Plan Information

Employee Health Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family
When available

☐ BlueOptions Plan # _____ ☐ BlueChoice (PPO) Plan # _____ ☐ BlueCare (HMO) Plan # _____

☐ BlueSelect Plan # _____ ☐ Truli For Health (HMO) Plan # _____ ☐ Other Plan # _____

☐ I am Refusing all Health Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: Date:

Section D: Vision Coverage Level and Plan Information

Employee Vision Coverage: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Child(ren) ☐ Family

Vision Plan Choice:

☐ I am Refusing all Vision Coverage at this time. I understand that if I decide to apply later coverage may not be available until the next open or special enrollment period. Signature: Date:

Section E: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign & date.*

Last Name: *(if different than employee)* First Name, M.I.	Social Security Number:	Birth Date:	Relation to You: Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Plan Type: Health	Plan Type: Vision	Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent: You Support	Dependent: Lives With You	Dependent: Is a Student	Ethnicity *optional* *Circle all that apply.*
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W
								☐	☐		☐			☐	☐	☐	A B C H N W

A) Asian/Pacific Islander
B) Black/African American
C) Caribbean Islander
H) Hispanic
N) Native American
W) White

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section F: Other Health Insurance Information *This section must be completed for claims processing* and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including Florida Blue and/or Truli for Health) that will be in effect after this coverage begins? ☐ Yes ☐ No

Florida Blue and/or Truli for Health Contract # _____ Medicare # _____ Pharmacy/Medicare D # _____

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage.

Prior Health Carrier Name:	Contract #:	Effective Date:

Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:

Signature:	Date:

Section G: Acceptance of Coverage

Plan Coverage Terms

I hereby apply for the coverage/membership that is selected on this form. My employer has selected health and/or vision coverage through Florida Blue and/or HMO coverage through Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:
1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until Florida Blue, Florida Blue HMO and/or Truli for Health accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract. I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue and/or Truli for Health to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

General Terms

I AGREE that in the event of any controversy or dispute between Florida Blue, Florida Blue HMO and/or Truli for Health, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of Florida Blue, Florida Blue HMO and/or Truli for Health. I also understand that my employer is responsible for notifying all employees of: 1. Effective dates; 2. All termination dates; 3. Any conversion, COBRA or ERISA rights or responsibilities; and 4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize Florida Blue and/or Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature:	Date:

05907
BlueOptions

Florida Blue

BlueOptions 05907
with Rx ($10/20%/NC) Generic Choices

Coverage Period: 01/01/2024 - 12/31/2024

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.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 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$7,500** Per Person/**$15,000** Family. Out-of-Network: **$15,000** Per Person/**$30,000** Family.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$8,200** Per Person/**$16,400** Family. Out-Of-Network: **$16,400** Per Person/**$32,800** Family.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2864529

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, Deductible does not apply/ Primary Care Visits: No Charge, Deductible does not apply - Visits 1-3;$30 Copay per remaining Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $60 Copay per Visit/ Virtual Visits: $60 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: 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, Deductible does not apply	50% Coinsurance	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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: $60 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	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	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	20% Coinsurance up to a maximum of $200 per Prescription at retail, 20% Coinsurance up to a maximum of $500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	——none——
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	——none——
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	——none——
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	——none——
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;$100 Copay per remaining Visit/ Urgent Care Visits: $100 Copay per Visit	Deductible + $100 Copay per Visit	——none——
If you have a	Facility fee (e.g., hospital	Deductible + 20% Coinsurance	Deductible + 50%	Inpatient Rehab Services limited to 30 days.

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)	
hospital stay	room)		Coinsurance	
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$60 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$60 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 25 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	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————

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)	
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	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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- 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 - Limited to 25 visits
- Most coverage provided outside the United States. See www.floridablue.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/agencies/ebsa 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 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/healthreform.

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

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? 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.

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	$7,500
Specialist Copayment	$60
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,500
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,830**

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

The plan's overall deductible	$7,500
Specialist Copayment	$60
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	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$7,500
Specialist Copayment	$60
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	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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.

05302
BlueOptions

Florida Blue

BlueOptions 05302

with Rx ($10/20%/NC) Generic Choices

Coverage Period: 01/01/2024 - 12/31/2024

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.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 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: **$10,000** Per Person/**$30,000** Family.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,350** Per Person/**$12,700** Family. Out-Of-Network: **$20,000** Per Person/**$40,000** Family.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2864528

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, Deductible does not apply/ Primary Care Visits: $30 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $55 Copay per Visit/ Virtual Visits: $55 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: 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, Deductible does not apply	50% Coinsurance	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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	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	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	20% Coinsurance up to a maximum of $200 per Prescription at retail, 20% Coinsurance up to a maximum of $500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	——none——
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	——none——
If you need immediate medical attention	Emergency room care	Physician Services: Deductible + 30% Coinsurance/ Facility: $300 Copay per Visit	Physician Services: In-Network Deductible + 30% Coinsurance/ Facility: $300 Copay per Visit	——none——
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	——none——
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;$60 Copay per	Deductible + $60 Copay per Visit	——none——

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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)	
		remaining Visit/ Urgent Care Visits: $60 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$55 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$55 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 25 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 + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment

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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.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
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	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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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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.floridablue.com/plancontracts/group.

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/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? 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.

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	$5,000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$70
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,130**

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

The plan's overall deductible	$5,000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$5,000
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Copayment	$300

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	$1,700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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.

03900
BlueOptions

Florida Blue

BlueOptions 03900

with Rx ($10/20%/NC) Generic Choices

Coverage Period: 01/01/2024 - 12/31/2024

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.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 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: **$4,500** Per Person.	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 policy, the overall family deductible must be met before the plan begins to pay.
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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,650** Per Person/**$13,300** Family. Out-Of-Network: **$20,000** Per Person/**$20,000** Family.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2864523

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, Deductible does not apply/ Primary Care Visits: $35 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: 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, Deductible does not apply	50% Coinsurance	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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$200 Copay per Visit	Deductible + 50% Coinsurance	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	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	20% Coinsurance up to a maximum of $200 per Prescription at retail, 20% Coinsurance up to a maximum of $500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: $300 Copay per Visit	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 50% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 50% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Emergency medical transportation	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;Deductible + 50% Coinsurance per remaining Visit/ Urgent Care Visits:	Deductible + 50% Coinsurance	————none————

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)	
		Deductible + 50% Coinsurance		
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 Copay per Admission	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$50 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Childbirth/delivery facility services	$1,500 Copay per Admission	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$50 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 25 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 + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.

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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)	
	Hospice services	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	————none————
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	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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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Does this plan meet the 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.

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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	$50
Hospital (facility) Copayment	$1,500
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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	$50
Hospital (facility) Copayment	$1,500
Other Coinsurance	50%

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	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Copayment	$1,500
Other Coinsurance	50%

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	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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.

52

BlueCare HMO

Florida Blue HMO

BlueCare 52
with Rx $10/$30/$50

Coverage Period: 01/01/2024 - 12/31/2024

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

Coverage for: Individual and/or Family | **Plan Type:** HMO

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 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,350** Per Person/**$12,700** 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2864518

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, Deductible does not apply/ Primary Care Visits: $40 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $65 Copay per Visit/ Virtual Visits: $65 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, Deductible does not apply	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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: $65 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)	Physician Office: $300 Copay per Visit/ Independent Diagnostic Testing Center: $200 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	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	————none————
	Preferred brand drugs	$30 Copay per Prescription at retail, $75 Copay per Prescription by mail	Not Covered	————none————
	Non-preferred brand drugs	$50 Copay per Prescription at retail, $125 Copay per Prescription by mail	Not Covered	————none————
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Physician Services: Deductible + 30% Coinsurance/ Facility: $300 Copay per Visit	Physician Services: In-Network Deductible + 30% Coinsurance/ Facility: $300 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;$85 Copay per remaining Visit/ Urgent Care Visits: $85 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)	Deductible + 30% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your

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)	
				benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	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	No Charge, Deductible does not apply	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$65 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	Deductible + 30% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge, Deductible does not apply	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$65 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 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 + 30% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Motorized Wheelchairs: $500 Copay/ All Other: No Charge, Deductible does not apply	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 + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your

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)	
				benefits/services may be denied.
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	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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- 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 - Limited to 30 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: 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/agencies/ebsa 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 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/healthreform.

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

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? 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.

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	$65
Hospital (facility) Coinsurance	30%
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,740**

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	$65
Hospital (facility) Coinsurance	30%
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	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$1,500
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other Copayment	$300

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	$1,500
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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.

Employees currently enrolled please use the following Employee Change Application to make any changes to your current plan including cancelling your coverage.

If you do not want to make any changes and wish to remain on the same policy please email Amy at akoon@giddenssecurity.com

Florida Blue | truli for health A Florida Blue Affiliate

Employee Change Application

Please type or write clearly in black or blue ink.

Section A: Current Information

Group Name:	Group #:	Division #:	Package #:
Employee Name: (Last, First Name, M.I.)	Social Security #:	Effective Date of Coverage:	Date of Event:

Section B: Coverage Change Information

Reason for Change:

- ☐ Adoption
- ☐ Open Enrollment
- ☐ Over-Aged Dependent
- ☐ Divorce
- ☐ Death
- ☐ Section 125
- ☐ Terminate Employment
- ☐ Location_____
- ☐ Leave of Absence/Layoff
- ☐ Marriage
- ☐ Return of Alternate Insurance
- ☐ Employee #_____
- ☐ Moved from Service Area
- ☐ Birth
- ☐ Loss of Coverage
- ☐ Plan Type:_____ (ex. PPO, HMO, RX)

Change Request Type:

- ☐ New Name:
- ☐ New Address:
- ☐ New Phone #:
- ☐ New Physician Name/ID:

Plan Coverage Type Requested: ☐ Add Health ☐ Delete Health ☐ Add Vision ☐ Delete Vision ☐ Change Plan: *Indicate Plan #*

Coverage Level Requested: ☐ Employee ☐ *Employee & Spouse ☐ *Employee & One Dependent ☐ *Employee & Children ☐ Family
**When available*

☐ Dependent Change *Complete Section C* ☐ Other Change:

Applicable to Group Administrator: The Affordable Care Act prohibits rescissions; cancellations cannot be submitted for the period in which a premium is collected. By submitting cancellation(s) you represent that you have not collected a premium from the employees/ dependents for coverage after the requested termination date.

Section C: Dependent Information *Attach separate sheet, if additional space is needed, with dependent information, sign and date.*

Last Name: *(if different than employee)* First Name, M.I.	Social Security Number	Birth Date	Relation to You			Plan Type		Sex (M or F)	Check if Disabled	Physician Name/ID *HMO only*	Existing Patient (Y/N)	Dependent			Ethnicity *optional . Check all that apply.* A - Asian/Pacific Islander B - Black/African American C - Caribbean Islander H - Hispanic N - Native American W - White
			Spouse (S)	Child (C)	Other (O)*	Health	Vision					You Support	Lives With You	Is a Student	
						☐	☐		☐			☐	☐	☐	☐A ☐B ☐C ☐H ☐N ☐W
						☐	☐		☐			☐	☐	☐	☐A ☐B ☐C ☐H ☐N ☐W
						☐	☐		☐			☐	☐	☐	☐A ☐B ☐C ☐H ☐N ☐W
						☐	☐		☐			☐	☐	☐	☐A ☐B ☐C ☐H ☐N ☐W

List the name of each dependent listed above that is married or has dependent child(ren) or lives outside of Florida.

* If you indicated "O" in "Relation to You" above for any dependents, please explain here:

Section D: Other Health Insurance Information *This section must be completed for claims processing* and Prior Coverage Information

In addition to this policy, do you or your dependents have any other insurance coverage (including Florida Blue and/or Truli for Health plans) that will be in effect after this coverage begins? ☐ Yes ☐ No
Florida Blue and/or Truli for Health Contract #_____Medicare #_____Pharmacy/Medicare D #_____

Complete the following only if this is the first time you or your dependents: (1) are enrolling for health insurance with this employer; (2) currently have health coverage; and/or (3) have any health coverage in the past 12 months that this coverage replaces OR you can attach a Certificate of Creditable Coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Prior Health Carrier Name	Contract #:	Effective Date:
Prior Employee Hire Date:	Cancel Date:	List names of all family members that were covered, including yourself:
Employee Signature:		Date:
Employer Signature:		Date:

Section E: Change Authorization

Plan Coverage Terms

I hereby authorize the changes to my Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue, Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc. DBA Truli for Health contract that is selected on this form. I understand and agree that the changes will not be effective until this application is accepted by Florida Blue, Florida Blue HMO and/or Truli for Health.

I authorize my employer to deduct from my earnings my premium contribution, if any, including any additional amounts required as a result of the changes indicated on this Health Change Application. I understand all of the following:

1. If my coverage/membership is to be issued and continued, I must meet all the group contract's requirements;
2. If my dependents' coverage/membership, if any, is to be issued and continued, my dependents must meet all the group contract's requirements;
3. If I must pay part or all of the premium, coverage/membership shall not become effective until Florida Blue, Florida Blue HMO and/or Truli for Health accepts this application and assigns an effective date.

I understand that membership granted to persons herein shall be subject to all provisions and limitations of the group contract.

I am aware that a change in coverage of dependents may affect the amount deducted from any wages (if any) for coverage/membership, and I hereby authorize such a change.

If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I recognize and authorize Florida Blue and/or Truli for Health to exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in, and administration of, HSAs.

I understand that if I am enrolling in an HSA qualified High Deductible Health Plan and I elect to receive Prior Carrier Credit under Florida law, my plan may no longer qualify as an HSA compatible plan.

General Terms

I AGREE that in the event of any controversy or dispute between Florida Blue, Florida Blue HMO and/or Truli for Health, I and my dependents must exhaust the appeal and/or grievance processes in the benefit/member handbook issued to me.

I understand that my employer is not an agent of Florida Blue, Florida Blue HMO and/or Truli for Health. I also understand that my employer is responsible for notifying all employees of:

1. Effective dates;
2. All termination dates;
3. Any conversion, COBRA or ERISA rights or responsibilities; and
4. All other matters pertaining to coverage/membership under the group contract.

When an overpayment is made, I authorize Florida Blue, Florida Blue HMO and/or Truli for Health to recover the excess from any person or entity that received it.

I acknowledge that Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership is contingent upon the complete, accurate disclosure of the information requested on this form.

I acknowledge that, if I apply for Florida Blue, Florida Blue HMO and/or Truli for Health coverage/membership later, coverage/membership may not be available until the next annual open enrollment or special enrollment period.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.

I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

I understand that a copy of the Summary of Benefits and Coverage (SBC) can be obtained by contacting my Group Administrator.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature:	Date: