



528 S. Edgewood Avenue
Jacksonville, FL 32205
904.384.8071 or 1.888.844.4345
Fax: 904.389.9931
info@giddenssecurity.com

Professional Armed and Unarmed Security Officers since 1982.

Open Enrollment for Health Insurance for year 2025

Open enrollment for health insurance coverage that will begin 1/01/25 will be from Wednesday 11/20/24 through Wednesday 12/04/24.

To be eligible employees must work a minimum of 30 hours every week and have been employed 90 days or more. If you are under 90 days and in your probationary period and want to sign up when you become eligible, please submit your application now through open enrollment. The coverage offered is for Health only. If you wish to sign up you must fill out the attached application and submit it to the office by the end of enrollment. Those wishing to decline coverage also need to complete the application and mark declining coverage and return as soon as possible or email AEscalona@giddenssecurity.com or Akoon@giddenssecurity.com stating that you wish to decline coverage. Those currently on the plan need to notify the office in writing if you plan to keep what you currently have or wish to discontinue coverage. (please note there are some price changes in the plans) If you wish to change plans you will need to complete the application and mark change plan.

Attached is the application along with a comparison of the four plans offered that meet the affordability and minimum coverage requirements of the Affordable Care Act.

Deductions are payable 1 month in advance so the first deduction for the policy beginning 1/1/25 will be 12/16/24.

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:

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

Change Request Type:

<input type="checkbox"/> New Name:	<input type="checkbox"/> New Address:
<input type="checkbox"/> New Phone #:	<input type="checkbox"/> 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: <i>(if different than employee)</i> First Name, M.I.	Social Security Number	Birth Date	Relation to You			Plan Type		Sex (M or F)	Check if Disabled	Physician Name/ID <i>HMO only</i>	Existing Patient (Y/N)	Dependent			Ethnicity <i>optional</i> <i>Check all that apply.</i> 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	
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> W
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> N <input type="checkbox"/> 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:



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

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: _____

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO and/or BeHealthy Florida, Inc., DBA Truli for Health. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

GIDDENS SECURITY CORP 2025

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	\$6,650 / \$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	30% after DED
Hospital Physician Services	20% after DED	30% after DED	Ded + 50%	
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	Hosp \$300 Copay Surg Center Ded+50%	30% after DED

EMERGENCY MEDICAL CARE

Emergency Room Facility Fee	20% after DED	\$300 Copay 30% after DED	DED + 50%	\$300 Copay 30% after DED
Emergency Medical Transportation				
Urgent Care Facility Fee	\$100 Copay	\$60 Copay	DED + 50%	\$85 Copay
ER Physician Services	20% after DED	DED + 30%	DED + 50%	Ded + 30%

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 EMERGENCY COVERAGE ONLY

Deductible Ind / Fam	\$15,000 / \$30,000	\$10,000 / \$30,000	\$4,500 / N/A	\$1500/Person
Coinsurance	50%	50%	50%	30%
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	\$16,400 / \$32,800	\$20,000 / \$40,000	\$20,000 / \$20,000	\$6350/Person

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

Member Tier	Employee Bi-Weekly Rates			
Employee Only	\$75.76	\$107.98	\$107.31	\$170.50
Employee + Spouse	\$542.02	\$615.48	\$613.96	\$760.23
Employee + Child	\$440.03	\$504.46	\$503.13	\$631.44
Family	\$877.16	\$980.24	\$978.10	\$1,183.40



BlueOptions 05907

with Rx (\$10/20%/NQ) Generic Choices

Coverage Period: 01/01/2025 - 12/31/2025

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/premium will be provided separately. 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.



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, <u>Deductible</u> does not apply/ Primary Care Visits: No Charge, <u>Deductible</u> does not apply - Visits 1-3:\$30 <u>Copay</u> per remaining Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Specialist</u> visit	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Specialist: \$60 <u>Copay</u> per Visit/ Virtual Visits: \$60 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	Preventive care/screening/immunization	No Charge, <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Physician administered drugs may have higher cost share. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$60 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	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/ios-ol-s-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
If you have outpatient surgery	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.
	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	<u>Deductible</u> + 20% <u>Coinsurance</u>	In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, <u>Deductible</u> does not apply	50% <u>Coinsurance</u> / Specialist Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	No Charge, <u>Deductible</u> does not apply	Physician Services: No Charge, <u>Deductible</u> does not apply/ Hospital: 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	\$60 <u>Copay</u> on initial Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	<u>Deductible</u> + 20% <u>Coinsurance</u>	In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	_____none_____
	Childbirth/delivery facility services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	_____none_____
	Home health care	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 35 visits.
If you need help recovering or have other special health needs	Rehabilitation services	\$60 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	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	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 60 days.
	Durable medical equipment	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	Hospice services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	_____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)	
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.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Habilitation services • Hearing aids 	<ul style="list-style-type: none"> • 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.)	
<ul style="list-style-type: none"> • Chiropractic care - Limited to 25 visits 	<ul style="list-style-type: none"> • 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.ccoio.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.* _____

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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 \$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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,300

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
<i>What isn't covered</i>	
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.floridable.com.

Section 1557 Notification: Discrimination is Against the Law

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

We provide:

- 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscordinator@fcflife.com



BlueOptions 05302

with Rx (\$10/20%/N/C) Generic Choices

Coverage Period: 01/01/2025 - 12/31/2025

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.



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 Copoly 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 <u>only</u> covered for In-Network providers.
	Specialist visit	Value Choice Specialist: \$20 Copoly per Visit/ Specialist: \$55 Copoly 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 <u>only</u> 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 <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: \$20 Copoly 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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.floridablue.com/members/ols-resources/pharmacy/medication-guide</p>	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.
<p>If you have outpatient surgery</p>	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
	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
<p>If you need immediate medical attention</p>	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

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

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 you have a hospital stay	Facility fee (e.g., hospital room)	remaining Visit/ Urgent Care Visits: \$60 Copay per Visit		
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	none
	Inpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Office visits	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	Prior Authorization may be required. Your benefits/services may be denied.
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	none
	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	none
If you need help recovering or have other special health needs	Rehabilitation services	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)	
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	and replacement of DME due to use/age. _____ 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.)	
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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.

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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 \$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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,300

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
<i>What isn't covered</i>	
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.

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 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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 - Information written in other languages

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- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

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Health and vision coverage (including FFP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscordinator@flife.com



BlueOptions 03900

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

Coverage Period: 01/01/2025 - 12/31/2025

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/pr/ovidersearch/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.



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 <u>only</u> 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. You may have to pay for services that aren't preventive. Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	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 <u>preventive</u> . Then check what your <u>plan</u> 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/ols-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
	Emergency room care	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	none
If you need immediate medical attention	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days. _____none_____
	Physician/surgeon fees	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	
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 <u>only</u> covered for In-Network providers. Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	
	Office visits	\$50 Copay on initial Visit	Deductible + 50% Coinsurance	
If you are pregnant	Childbirth/delivery professional services	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) _____none_____
	Childbirth/delivery facility services	\$1,500 Copay per Admission	Deductible + 50% Coinsurance	
	Home health care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	
	Rehabilitation services	\$50 Copay per Visit	Deductible + 50% Coinsurance	
If you need help recovering or have other special health needs	Habilitation services	Not Covered	Not Covered	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. Not Covered
	Skilled nursing care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	
	Durable medical equipment	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	

For more information about limitations and exceptions, see the [plan](http://www.floridablue.com/plancontracts/group) 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)	
	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.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Habilitation services • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-preferred brand drugs • Pediatric dental check-up • Pediatric eye exam
<ul style="list-style-type: none"> • 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.)

<ul style="list-style-type: none"> • Chiropractic care - Limited to 25 visits 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.floridablue.com. 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S.
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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.ccoio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may

For more information about limitations and exceptions, see the plan or policy document at www.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 \$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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,300

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
<i>What isn't covered</i>	
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.

Section 1557 Notification: Discrimination is Against the Law

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

We provide:

- 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FEP members):


Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscordinator@fclife.com

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/pr/ovidersearch/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.



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, <u>Deductible</u> does not apply/ Primary Care Visits: \$40 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	Specialist visit	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Specialist: \$65 <u>Copay</u> per Visit/ Virtual Visits: \$65 <u>Copay</u> per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	Preventive care/screening/immunization	No Charge, <u>Deductible</u> 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 <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$65 <u>Copay</u> 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 <u>Copay</u> per Visit/ Independent Diagnostic Testing Center: \$200 <u>Copay</u> 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/fools-resources/pharmac/medication-guide	Generic drugs	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> 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	\$30 <u>Copay</u> per Prescription at retail, \$75 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	\$50 <u>Copay</u> per Prescription at retail, \$125 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	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)	<u>Deductible</u> + 30% <u>Coinsurance</u>	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	<u>Deductible</u> + 30% <u>Coinsurance</u>	Not Covered	none
	Emergency room care	Physician Services: <u>Deductible</u> + 30% <u>Coinsurance</u> / Facility: \$300 <u>Copay</u> per Visit	Physician Services: <u>In-Network Deductible</u> + 30% <u>Coinsurance</u> / Facility: \$300 <u>Copay</u> per Visit	none
If you need immediate medical attention	Emergency medical transportation	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	<u>Out-of-Network</u> only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2,\$85 <u>Copay</u> per remaining Visit/ Urgent Care Visits: \$85 <u>Copay</u> per Visit	Not Covered	<u>Out-of-Network</u> only covered out-of-state.
	Facility fee (e.g., hospital room)	<u>Deductible</u> + 30% <u>Coinsurance</u>	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)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	benefits/services may be denied. _____none_____
	Outpatient services	No Charge, <u>Deductible</u> does not apply	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	No Charge, <u>Deductible</u> does not apply	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	\$65 Copay on Initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not Covered	_____none_____
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	_____none_____
	Home health care	No Charge, <u>Deductible</u> 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.
If you need help recovering or have other special health needs	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, <u>Deductible</u> does not apply	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to usage. 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)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	benefits/services may be denied.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	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.)

<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Habilitation services • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Pediatric dental check-up • Pediatric eye exam 	<ul style="list-style-type: none"> • Pediatric glasses • Private-duty nursing • Routine eye care (Adult) • Routine foot care unless for treatment of diabetes • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Chiropractic care - Limited to 30 visits 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.floridablue.com.
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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.ccio.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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

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
<i>What isn't covered</i>	
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.

Section 1557 Notification: Discrimination is Against the Law

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

We provide:

- 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including FFP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life, and disability coverage:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@flife.com

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.