

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.





Employee Change ApplicationPlease type or write clearly in black or blue ink.

Section	A: Curre	ent Informat	tion																	
Group N						G	roup	#:				Divi	sion	#:		Package #:				
Employe	e Name	: (Last, First	t Name, M.I.))					9	Soci	al Security#:				Effectiv Covera	ve Date of	Date of Event:			
Section I	B: Cove	rage Chan	ge Informati	on																
Reason fo Change:		Adoption Open Enrol Over-Aged Divorce	lment Dependent	□ S □ T E	ermi	on 12 nate oyme			[□ M Re Ins	eave of Abse arriage etum of Alterr surance mployee #		.ayof	<u>[</u>	Birth Loss Plan	Moved from Service Area Birth Loss of Coverage Plan Type:_ x. PPO, HMO, RX)				
Change	□New	Name:																		
Request	□New	Address:																		
Туре:	□New	Phone #:			□Ne	w Pł	nysic	ian l	Nam	e/IC):									
Plan Coverage Type Requested: Add Health Delete Health Add Vision Delete Vision Change Plan: Indicate Plan #										te Plan #										
Coverage *When a	e Level Re vailable	equested: 🗖	l Employee 🛭]*Em	ploy	ee &	Spo	use	□ *[Emp	loyee & One	Depe	ende	nt [⊡*Em∣	ployee & Childre	n 🗖 Family			
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which a p	remium	is collected.	trator: The Aff By submitting or the requeste	a can	cella	tion(s) vo	u rer	ibits orese	resc ent t	issions; cance hat you have	ellatio not c	ns ca ollec	anno ted :	t be si a pren	ubmitted for the nium from the er	period in mployees/			
Section	C: Depe	endent Info	ormation Atta	ach se	epar	ate s	heet	, if a	dditi	onal	space is nee	ded,	with	dep	ender	nt information, si	gn and date.			
Last Nam (if differe	ection C: Dependent Information Attach separate sheet, if additional space is needed, with dependent information, sign and contact Name: Social Birth Relation Plan Physician Dependent Ethnicity optional to You Type Rame/ID Security Date To You																			
than emp First Nam		Number		Spouse (S)	Child (C)	Other (O)*	Health	Vision	Sex (M or F)	Check if Disabled	HMO only	Existing Patient (Y/N)	You Support	Lives With You	Is a Student	o 14 - Native American				
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* If you in	dicated	"O" in "Re	lation to You'	" abo	ove f	or a	ny di	eper	nden	its, p	olease explai	n her	e:							
Section D	D: Other	r Health Ins	surance Infor	mati	on 7	This s	ectic	n m	ust b	e cc	ompleted for	claims	s pro	cess	ing <mark>an</mark>	d Prior Coverag	e Information			
In additior olans) that Florida Blu	n to this p will be i e and/or	policy, do y in effect afte Truli for He	ou or your de er this coverag alth Contract	epend ge be	dent egin	s ha s? E	ve ar Yes	/ 🔟 i	No			_		_		da Blue and/or 1 are D#	Γruli for Health			
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.										DR you can nsurer files a										
Prior Hea	lth Carrie	er Name									Contract #:				Ef	ffective Date:				
Prior Emp	oloyee H	ire Date:		Car	ncel	Date):		L	ist r	ames of all f self:	amily	me	mbe	rs tha	t were covered,	including			
Employee	e Signatı	ure:							1/1/2						D	ate:				
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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 Informa Group Name:	tion																					
					_	Gr	OUR	o #:							Divi	eio	n #:		Da	okar	ge#	<i>t</i> .
						G	ou	<i>J</i> #.							DIVI	510	11 #	•	Га	CKa	ge #	٠.
Effective Date of Coverage	: Date of Hire	E: Location	n #:		E	mp	loy	ee#	ŧ;	Jc	b Ti	itle:							J			
Work Status:	at Work 🗌	Cobra Ref	ired	Retir	em	ent	Da	te:				Paid: □	Но	urly		Sa	lary		Оре	en E	nrol	llm
Section B: Employee Infor	nation		'																			
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Street Address:							Α	pt. 7	#: Ci	ty:							Sta	ate:	Zip	_		
County:	Ph	one:						ľ	Marita ∃ Sin			: Varried [☐ Dis	orc	ed.		\\/i	dow	ed.	Į	_ega	ally
Physician Name / ID # HMO	only:	Existing Patier							ce: op	tiona	al - fo	or data coll					s on	ly			t to a	
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Section C: Health Coverage																						
Employee Health Coverage: * <i>When available</i>	☐ Employed	e 🗌 *Employe	ee & :	Spou	se] *E	mpl	oyee	& O	ne D	ependent		*Em	plo	yee	: & C	Child	(ren) [] Fa	ımil
☐ BlueOptions Plan #		Blue	Choic	e (P	PO) PI	lan :	# _				□ Blue	Car	e (H	IMC) P	lan	#				
☐ BlueSelect Plan #		Truli	For H	ealth	(H	IMO) PI	an #	Ł			☐ Othe	er Pla	an#								
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Section D: Vision Coverage	ge Level and	Plan Informa	ation																			
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Vision Plan Choice: I am Refusing all Visio next open or special elemants. Section E: Dependent Info Last Name: (if different than employee) First Name, M.I.	n Coverage nrollment per ormation Atta Social Security	at this time. I uitiod. Signatu	under ire: heet, Re	if add	d t	child (DPC) Olido	if I I sp	ded PI	is ne an pe	Check if Disabled	PPIY I	later cove ith depend Physician Name/ID	dent (N/A)	Del hoddus no Y	ay rrmae	not atio.	be Dan, Si Eth Cir (A) A A A	ava ate: ign connic rcle Asian Black Hisp: Nativ White B	& da & da ity c all t n/Pa k/Afri bbea anic ve Ar te C C	le unate. Option that cific ican in Isl. H	onal apples and	/ voly. Inder erical erical erical way.

Section F: Other Health Insurance Informa	tion This section i	must he completed for claim	ns processing and Prior Coverage Information
In addition to this policy, do you or your depender effect after this coverage begins? Yes No	its have any other in		
Florida Blue and/or Truli for Health Contract	, #	Medicare #	Pharmacy/Medicare D #
Complete the following only if this is the first time ye coverage; and/or (3) have any health coverage in t	ou or your depende he past 12 months t	nts: (1) are enrolling for health that this coverage replaces OR	insurance with this employer; (2) currently have healtl I 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 r	nembers that were covered, including yourself
Signature:	1		Date:
Section G: Acceptance of Coverage			
Plan Coverage Terms I hereby apply for the coverage/membership that Blue and/or HMO coverage through Florida Blue			ted health and/or vision coverage through Florida
I authorize my employer to deduct from my earni 1. If my coverage/membership is to be issued an 2. If my dependents' coverage/membership, if an 3. If I must pay part or all of the premium, covera HMO and/or Truli for Health accepts this applicat	d continued, I must y, is to be issued a ge/membership sh	t meet all the group contract's and continued, my dependents all not become effective until l	requirements; s must meet all the group contract's requirements;
I understand that membership granted to persons I am aware that a change in coverage of depend membership, and I hereby authorize such a char	ents may affect the		
If I am enrolling in a high-deductible health plan of section 223, I recognize and authorize Florida Blue preferred financial partner(s) for the purposes of in	e and/or Truli for He	ealth to exchange certain limite	at (HSA) under Internal Revenue Service Code and information obtained from this application with its
I understand that if I am enrolling in an HSA qual plan may no longer qualify as an HSA compatible		le Health Plan and I elect to r	eceive Prior Carrier Credit under Florida law, my
General Terms I AGREE that in the event of any controversy or exhaust the appeal and/or grievance processes in			and/or Truli for Health, I and my dependents must
I understand that my employer is not an agent of responsible for notifying all employees of: 1. Effect and 4. All other matters pertaining to coverage/m	ctive dates; 2. All te	ermination dates; 3. Any conve	Health. I also understand that my employer is ersion, COBRA or ERISA rights or responsibilities;
When an overpayment is made, I authorize Floric entity that received it.	la Blue and/or Flori	ida Blue HMO and/or Truli for	Health to recover the excess from any person or
I acknowledge that Florida Blue, Florida Blue HM disclosure of the information requested on this for		lealth coverage/membership	is contingent upon the complete, accurate
I acknowledge that, if I apply for Florida Blue, Florida Blue, Florida Blue, Florida available until the next annual open enrollmen			membership later, coverage/membership may not
I represent that the statements on this application	are true and comp	plete to the best of my knowle	dge and belief.
I understand and agree that misrepresentations, of termination of coverage/membership. I agree to be			
I understand that any person who knowingly claim or an application containing any false			
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 SE	CURITY 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				以外型以下 1/2 图
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,	\$8,200 / \$16,400	\$6,350 / \$12,700	\$6,650 / \$13,300	\$6,350 / \$12,700
Coinsurance + Rx) Wellness / Preventive Care	\$0 Copay	\$0.Comerc	¢o comou	†0 C
PHYSICIAN SERVICES	30 Сорау	\$0 Copay	\$0 Copay	\$0 Copay
PCP Office Copay	\$0 COPAY up to 3 visits	\$30 Copay	\$35 Copay	\$40 Copay
	then \$30 Copay			
Specialist Office Copay	Specialist: \$60 Copay	\$55 Copay	\$50 Copay	\$65 Copay
HOSPITAL CARE	· · · · · · · · · · · · · · · · · · ·		Man at All	
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		AND PERMIT	7 Sell, 18 K. 1	NAME OF THE PERSON
Emergency Room Facility Fee Emergency Medical	20% after DED	\$300 Copay 30% after DED	DED + 50%	\$300 Copay 30% after DED
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				Single British
Deductible	N/A	N/A	N/A	N/A
	Generic: \$10 Copay	Generic: \$10 Copay	Generic: \$10 Copay	Generic: \$10 Copay
Prescription Drug Benefit	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 (OVERAGE ONLY			PV (25 - 17) 4
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 em	ployer if you want more detail about y	your coverage and costs, or you can g	et the complete terms in the po	licy or plan document at the
Member Tier		Employee Bi-We		* * * * * * * * * * * * * * * * * * * *
Employee Only Employee + Spouse	\$75.76	\$107.98	\$107.31	\$170.50
	\$542.02 \$440.03	\$615.48 \$504.46	\$613.96 \$503.13	\$760.23 \$631.44
Employee + Child	J++0.03			

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



BlueOptions 05907

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

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

This is only a summary. For more information about your coverage, or to get a copy of the share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. 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

For general definitions of confidence of the Glossary. You can view the	For general definitions of common terms, such as <u>allowed amount, balance billing, coinsurance, copayme</u> Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583	For general definitions of common terms, such as <u>allowed amount</u> , <u>balance billing</u> , coinsurance, <u>copayment</u> , <u>deductible, provider</u> , or other <u>underlined</u> terms see the Glossary at <u>www.floridablue.com/plancontracts/group</u> 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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at www healthcare covered preventive services at www healthcare covered preventive.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-</u> pocket limit for this <u>plan?</u>	In-Network: \$8,200 Per Person/\$16,400 Family. Out-Of-Network: \$16,400 Per Person/\$32,800 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family out-of-pocket limits.
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 <u>network provider</u> ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before the formula of the provider of the prov</u>
Do you need a <u>referral</u> to see a <u>specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		If you have a test		office or clinic	If you visit a health	Common Medical Event
	Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need
	Deductible + 20% Coinsurance	Value Choice Specialist: \$20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: \$60 Copay per Visit	No Charge, <u>Deductible</u> does not apply	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$60 Copay per Visit/ Virtual Visits: \$60 Copay per Visit	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	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	50% <u>Coinsurance</u>	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Will Pay Out-of-Network Provider (You will pay the most)
defiled.	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be	Tests performed in hospitals may have higher cost share.	Physician administered drugs may have higher cost share. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.	Virtual Visit services are <u>only</u> covered for In- Network providers.	Limitations, Exceptions, & Other Important Information

ir you nave a	attention	If you need		If you have outpatient surgery		resources/pharmac y/medication-guide	ue.com/members/to	about prescription drug coverage is available at https://www.floridabl	to treat your illness or condition	Common Medical Event
Facility fee (e.g., hospital	Urgent care	transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Specialty drugs	Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Services You May Need
Facility fee (e.g., hospital Deductible + 20% Coinsurance Deduction	Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2;\$100 <u>Copay</u> per remaining Visit/ Urgent Care Visits: \$100 <u>Copay</u> per Visit	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + 50%	Deductible + \$100 Copay per Visit	In-Network Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: <u>In-</u> <u>Network Deductible</u> + 20% Coinsurance	Deductible + 50% Coinsurance	Not Covered	Not Covered	Not Covered	Not Covered	Will Pay Out-of-Network Provider (You will pay the most)
Inpatient Rehab Services limited to 30 days.	none	none	none-	none	none	Up to 30 day supply for retail. Not covered through Mail Order.	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.	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.	Limitations, Exceptions, & Other Important Information

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

		health needs	other special	If you need help recovering or have			n you are pregnant	if you are programs	substance abuse services	If you need mental health, behavioral		ilospilai stay	Common Medical Event
Hospice services	Durable medical equipment	Skilled nursing care	nabilitation services	Rehabilitation services	Home health care	services	professional services	Office visits	Inpatient services	Outpatient services	Physician/surgeon fees	room)	Services You May Need
Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Not Covered	\$60 <u>Copay</u> per Visit	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	\$60 Copay on initial Visit	No Charge, <u>Deductible</u> does not apply	No Charge, <u>Deductible</u> does not apply	Deductible + 20% Coinsurance		What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Not Covered	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	In-Network Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	50% Coinsurance/ Specialist Virtual Visits: Not Covered	In-Network Deductible + 20% Coinsurance	Coinsurance	Will Pay Out-of-Network Provider (You will pay the most)
none	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.	Coverage limited to 60 days.	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.	Coverage limited to 35 visits.	none	none	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	Prior Authorization may be required. Your benefits/services may be denied.	Virtual Visit services are only covered for In- Network providers.	none		Limitations, Exceptions, & Other Important Information

			Eveluded Comings of Other Comments	Eveluded Comings
Not Covered	Not Covered	Not Covered	Cilidrett a defital cileck-up	
INCL COAGLED		NILLO	Children's dontal about	
Not Covered	Not Covered	Not Covered	Clindiell a Glasses	dental or eve care
1400 COVELED			Children's alongo	
Not Covered	Not Covered	Not Covered	Children's dye exam	If your child needs
			Children's our aven	
Information	(You will pay the most)	(You will pay the least)		
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Litilidations, exceptions, & Other important	Out-of-Notwork Drowids	Network Provider	Services rou May Need	Medical Event
	will ray	Tillar Log	2000	
	Will Day	What You Will Day		Common

EXCIUDED Services & Other Covered Services:

 Weight loss programs 	i culatic eye exail!	Hearing aids
 Routine foot care unless for treatment of diabetes 	Pediatric over over	Habilitation services
 Routine eye care (Adult) 	Podiation de la	Dental care (Adult)
 Private-duty nursing 	Long-term care	Cosmetic surgery
 Pediatric glasses 	 Intertility treatment 	Bariatric surgery
Acrimination and a list of any other excluded services.)	k your policy or plan document for more in	Actining thire

Chiropractic care - Limited to 25 visits e. Tills isit t a complete list. Please see your plan document,)

Most coverage provided outside the United States. See www.floridablue.com. Non-emergency care when traveling outside the

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 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 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance 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 Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform. 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 department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may 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 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 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, 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 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

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.

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	Does this plan meet the Minimum Value Standards? Yes
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-To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.-

About these Coverage Examples:



amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage. This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be

(9 months of in-network pre-natal care and a Peg is Having a Baby hospital delivery)

Specialist Copayment The plan's overall deductible

Other No Charge Hospital (facility) Coinsurance

This EXAMPLE event includes services like:

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

Specialist Copaymen The plan's overall deductible

\$7,500

20% \$60

Other Coinsurance

20%

Hospital (facility) Coinsurance \$7,500 \$60

Mia's Simple Fracture

(<u>in-network</u> emergency room visit and follow up care)

Specialist Copayment The plan's overall deductible

\$7,500

20% \$60

Other Coinsurance Hospital (facility) Coinsurance

Emergency room care (including medical This EXAMPLE event includes services like:

Diagnostic test (x-ray) supplies,

Rehabilitation services (physical therapy) Durable medical equipment (crutches)

In this example, Joe would pay The total Joe would pay is Coinsurance **Total Example Cost** Limits or exclusions Copayments **Deductibles** What isn't covered Cost Sharing \$5,600 \$500 \$800 \$0

In this example, Peg would pay:

Cost Sharing

\$7,500

\$200

\$70

Total Example Cost

\$12,700

Durable medical equipment (glucose meter)

Prescription drugs

Diagnostic tests (blood work)

disease education)

Primary care physician office visits (including This EXAMPLE event includes services like:

Specialist visit (anesthesia)

Diagnostic tests (ultrasounds and blood work)

Childbirth/Delivery Facility Services Childbirth/Delivery Professional Services Specialist office visits (prenatal care)

\$2,300	The total Mia would pay is
\$0	Limits or exclusions
	What isn't covered
\$0	Coinsurance
\$300	Copayments
\$2,000	Deductibles
	Cost Sharing
	In this example, Mia would pay:
\$2,800	Total Example Cost

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

The total Peg would pay is

\$7,830

\$60

Limits or exclusions

What isn't covered

Coinsurance Copayments Deductibles

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:

section1557coordinator@floridablue.com	1-800-955-8770 (TTY) Fax: 1-904-301-1580	1-800-477-3736 x29070	Jacksonville, FL 32246	4800 Deerwood Campus Parkway, DCC 1-7	Section 1557 Coordinator	members):	Health and vision coverage (including FEP
	civilrightscoordinator@fclife.com	1-800-955-8770 (TTY)	1-800-260-0331	Little Rock AR 72223	17500 Chenal Parkway	Civil Rights Coordinator	Dental, life, and disability coverage.

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.



BlueOptions 05302

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

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

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

Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the 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. share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/.</u>
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> 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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the 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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

	If you have a test		If you visit a health care provider's office or clinic		Common Medical Event
Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need
Deductible + 30% Coinsurance	Value Choice Specialist: \$20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	No Charge, <u>Deductible</u> does not apply	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$55 Copay per Visit/ Virtual Visits: \$55 Copay per Visit	Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: \$30 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	50% Coinsurance	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Vill Pay Out-of-Network Provider (You will pay the most)
Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.	Tests performed in hospitals may have higher cost share.	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.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for ln-Network providers.	Limitations, Exceptions, & Other Important Information

	attention	If you need	If you have outpatient surgery		resources/pharmac y/medication-guide	ue com/members/to	More information about prescription drug coverage is available at https://www.floridable.	If you need drugs to treat your illness or condition	Common Medical Event
Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Specialty drugs	Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Services You May Need
Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2;\$60 <u>Copay</u> per	Deductible + 30% Coinsurance	Physician Services: <u>Deductible</u> + 30% <u>Coinsurance/</u> Facility: \$300 <u>Copay</u> per Visit	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	\$10 Copay per Prescription at retail, \$25 Copay per Prescription by mail	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + \$60 Copay per Visit	In-Network Deductible + 30% Coinsurance	Physician Services: In- Network Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In- Network Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Not Covered	Not Covered	Not Covered	Not Covered	Vill Pay Out-of-Network Provider (You will pay the most)
none	none	none	попе	none	Up to 30 day supply for retail. Not covered through Mail Order.	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.	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.	Limitations, Exceptions, & Other Important Information

	Skilled	health needs Habilita	If you need help Rehabi recovering or have other special	Home !	Childbirt services	If you are pregnant Childbin profess			d mental havioral	hospital stay Physici	If you have a room)		Common Serv Medical Event	
Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	visits	Inpatient services	Outpatient services	Physician/surgeon fees	Facility fee (e.g., hospital room)		Services You May Need	
Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Not Covered	\$55 <u>Copay</u> per Visit	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	\$55 <u>Copay</u> on initial Visit	No Charge, <u>Deductible</u> does not apply	No Charge, <u>Deductible</u> does not apply	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	remaining Visit/ Urgent Care Visits: \$60 Copay per Visit	What You Will Pay Network Provider (You will pay the least) (You will pay the least)	Will Company of the C
Deductible + 50%	Deductible + 50% Coinsurance	Not Covered	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	In-Network Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	50% <u>Coinsurance/</u> Specialist Virtual Visits: Not Covered	In-Network Deductible + 30% Coinsurance	Deductible + 50% Coinsurance		Out-of-Network Provider (You will pay the most)	
Excludes vehicle modifications, home	Coverage limited to 60 days.	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.	Coverage limited to 35 visits.	none	none	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	Prior Authorization may be required. Your benefits/services may be denied.	Virtual Visit services are only covered for In- Network providers.	none	Inpatient Rehab Services limited to 30 days.		Limitations, Exceptions, & Other Important Information	

Not Covered	Not Covered	Not Covered	Children's dental check-up	
Not Covered	Not Covered	Not Covered	Children's glasses	dental or eve care
Not Covered	Not Covered	Not Covered	Children's eye exam	If your child needs
none	Coinsurance	Deductible + 30 % Collishing lice	Troples oct vices	
	Deductible + 50%	Doductible + 20% Coincines	Hospico soprioss	
and replacement of DME due to use/age.				
HIGHHAUGH	(You will pay the most)	(You will pay the least)		
Information	Out-of-Network Provider	Network Provider	Services You May Need	Medical Event
imitations Exceptions & Other Important	Vill Pay	What You Will Pay		Common

Excluded Services & Other Covered Services:

•	•	•	•	•	•	S
Hearing aids	Habilitation services	Dental care (Adult)	Cosmetic surgery	Bariatric surgery	Acupuncture	Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more infor
	•	•	•	•	•	Check
	Pediatric eye exam	Pediatric dental check-up	Non-preferred brand drugs	Long-term care	Infertility treatment	your policy or plan document for more information
	Weight loss programs	 Routine foot care unless for treatment of diabetes 	 Routine eye care (Adult) 	 Private-duty nursing 	Pediatric glasses	rmation and a list of any other excluded services.)

 Chiropractic care - Limited to 25 visits 	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please s
•	to these
Most cove	e services.
Most coverage provided outside the United	This isn't
ded outside	a comple
e the Uni	te list. P
ted	lease se
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States. See www.floridablue.com. Most coverage provided outside the United Non-emergency care when traveling outside the

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 Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance 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

department. For non-federal governmental group health <u>plans</u> and church <u>plans</u> that are group health <u>plans</u> contact your employee services department. You may 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 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 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, 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 Your <u>Grievance</u> and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a claim. This complaint is called a

of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform. 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

Does this plan provide Minimum Essential Coverage? Yes

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 Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,

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.

About these Coverage Examples:



amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage. This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be

is \$1,300	The total Joe would pay is	\$6,130	The total Peg would pay is
\$0	Limits or exclusions	\$60	Limits or exclusions
'covered	What isn't		What isn't covered
\$800	Coinsurance	\$1,000	Coinsurance
\$500	Copayments	\$70	Copayments
\$0	Deductibles	\$5,000	Deductibles
haring	Cost St		Cost Sharing
d pay:	In this example, Joe would		In this example, Peg would pay:
\$5,600	Total Example Cost	\$12,700	Total Example Cost
udes services like: e visits (including k) t (glucose meter)	This EXAMPLE event including Primary care physician office disease education) Diagnostic tests (blood work Prescription drugs Durable medical equipment	es like: \$ work)	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)
<u>surance</u> \$5,000 \$55 30%	 The <u>plan's</u> overall <u>dedu</u> <u>Specialist Copayment</u> Hospital (facility) <u>Coins</u> Other <u>Coinsurance</u> 	\$5,000 \$55 30% \$0	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist Copayment</u> Hospital (facility) <u>Coinsurance</u> Other <u>No Charge</u>
type 2 Diabetes atwork care of a well- condition)	Managing Joe's t (a year of routine <u>in-ne</u> controlled c	are and a	Peg is Having a Baby (9 months of <u>in-network</u> pre-natal care and a hospital delivery)
	Q = < 0	Joe's type 2 Diabete ine in-network care of a w ntrolled condition) all deductible wment y) Coinsurance nce ent includes services lik bian office visits (including ood work) uipment (glucose meter) ost oe would pay: Cost Sharing Cost Sharing hat isn't covered is	Managing Joe's type 2 Diabete (a year of routine in-network care of a w specialist Copayment Hospital (facility) Coinsurance Hospital (facility) Coinsurance 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 In this example, Joe would pay: Copayments Copayments Copayments Copayments Coinsurance What isn't covered Limits or exclusions The total Joe would pay is

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

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

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

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

Health and vision coverage (including FEP	Dental, life, and disability coverage:
members):	Civil Rights Coordinator
Section 1557 Coordinator	17500 Chenal Parkway
4800 Deerwood Campus Parkway, DCC 1-7	Little Rock, AR 72223
Jacksonville, FL 32246	1-800-260-0331
1-800-477-3736 x29070	1-800-955-8770 (TTY)
1-800-955-8770 (TTY)	civilrightscoordinator@fclife.com
section1557coordinator@floridablue.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



BlueOptions 03900

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

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

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

Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the 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. share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would

The second secon	- Control of the cont	acia gli cub or call 1-000-332-2303 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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> 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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the 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 <u>network provider</u> ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist?</u>	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.

	If you have a test		If you visit a health care provider's office or clinic		Common Medical Event
Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need
\$200 <u>Copay</u> per Visit	Value Choice Specialist: \$20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 50% Coinsurance	No Charge, <u>Deductible</u> does not apply	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$50 Copay per Visit/ Virtual Visits: \$50 Copay per Visit	Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: \$35 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
<u>Deductible</u> + 50% <u>Coinsurance</u>	Deductible + 50% Coinsurance	50% <u>Coinsurance</u>	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	fill Pay Out-of-Network Provider (You will pay the most)
Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.	Tests performed in hospitals may have higher cost share.	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.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for ln-Network providers.	Limitations, Exceptions, & Other Important Information

immediate medical attention	ed te medical		If you have outpatient surgery		resources/pharmac y/medication-guide	ue com/members/fo	More information about prescription drug coverage is available at https://www.foridable.	If you need drugs to treat your illness or condition	Common Medical Event
Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Specialty drugs	Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Services You May Need
Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2; <u>Deductible</u> + 50% <u>Coinsurance</u> per remaining Visit/ Urgent Care Visits:	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: \$300 Copay per Visit	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: <u>In-</u> <u>Network Deductible</u> + 50% <u>Coinsurance</u>	Deductible + 50% Coinsurance	Not Covered	Not Covered	Not Covered	Not Covered	Vill Pay Out-of-Network Provider (You will pay the most)
none	none	none	none	none	Up to 30 day supply for retail. Not covered through Mail Order.	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.	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.	Limitations, Exceptions, & Other Important Information

	If you need help recovering or have other special health needs					If you are pregnant		health, or substance abuse services	If you need mental health, behavioral	nospital stay	If you have a		Common Medical Event
Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services	Outpatient services	Physician/surgeon fees	Facility fee (e.g., hospital room)		Services You May Need
Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Not Covered	\$50 <u>Copay</u> per Visit	Deductible + 50% Coinsurance	\$1,500 Copay per Admission	Deductible + 50% Coinsurance	\$50 <u>Copay</u> on initial Visit	No Charge, <u>Deductible</u> does not apply	No Charge, <u>Deductible</u> does not apply	Deductible + 50% Coinsurance	\$1,500 Copay per Admission	Deductible + 50% Coinsurance	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Not Covered	<u>Deductible</u> + 50% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Physician Services: No Charge, <u>Deductible</u> does not apply/ Hospital: 50% Coinsurance	50% <u>Coinsurance/</u> Specialist Virtual Visits: Not Covered	In-Network Deductible + 50% Coinsurance	Deductible + 50% Coinsurance		Vill Pay Out-of-Network Provider (You will pay the most)
modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.	Coverage limited to 60 days.	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.	Coverage limited to 35 visits.	none	none	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	Prior Authorization may be required. Your benefits/services may be denied.	Virtual Visit services are <u>only</u> covered for In- Network providers.	none	Inpatient Rehab Services limited to 30 days.		Limitations, Exceptions, & Other Important Information

Excluded Services & Other Covered Services:

	Acupuncture Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) Habilitation services Hearing aids	ces Your Plan Generally Does NOT Cover (Check cupuncture eariatric surgery ental care (Adult) earing aids	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 Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) Habilitation services Hearing aids Acupuncture Infertility treatment Long-term care Non-preferred brand drugs Non-preferred brand drugs Pediatric eye exam Routine eye care (Adult) Routine foot care unless for treatment of deck-up 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.) Chiropractic care - Limited to 25 visits

Most coverage provided outside the United States. See www.floridablue.com. Non-emergency care when traveling outside the

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 Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance 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 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

department. For non-federal governmental group health <u>plans</u> and church <u>plans</u> that are group health <u>plans</u> contact your employee services department. You may 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 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 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 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, 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

of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform. 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

Does this plan provide Minimum Essential Coverage? Yes

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. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,

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 <u>plan</u> might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage. amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

Other No Charge	Hospital (facility) Copayment	Specialist Copayment	The plan's overall deductible
\$0	\$1,500	\$50	\$1,500

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

Other Coincurance	Hospital (facility) Copayment	Specialist Copayment	The plan's overall deductible	
лo/	\$1,500	\$50	\$1,500	

Mia's Simple Fracture

in-network emergency room visit and follow up care)

Other Coinsurance	Hospital (facility) Copayment	Specialist Copayment	The plan's overall deductible
50%	\$1,500	\$50	\$1,500
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3	\$1,500 50%	\$50
	Hospital (facility) <u>Copayme</u>Other <u>Coinsurance</u>	 Specialist Copayment

Other Coinsurance	lospital (facility) Copayment	pecialist Copayment	he plan's overall deductible
50%	\$1,500	\$50	\$1,500

This EXAMPLE event includes services like:

disease education) Primary care physician office visits (including

Prescription drugs Diagnostic tests (blood work)

Durable medical equipment (glucose meter)

Specialist visit (anesthesia)

Diagnostic tests (ultrasounds and blood work)

Childbirth/Delivery Facility Services Childbirth/Delivery Professional Services

In this example, Peg would pay:

Cost Sharing

Total Example Cost

\$12,700

Limits or exclusions

What isn't covered

The total Peg would pay is

\$3,060

\$60

Coinsurance

Deductibles

Copayments

\$1,600

80

\$1,400

Specialist office visits (prenatal care)

This EXAMPLE event includes services like:

This EXAMPLE event includes services like:

supplies) Emergency room care (including medical

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

In this example, Joe would pay: Limits or exclusions Coinsurance Deductibles **Total Example Cost** The total Joe would pay is Copayments What isn't covered Cost Sharing \$1,300 \$5,600 \$800 \$500 \$0 \$0 The total Mia would pay is

The total Mia would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	Cost Sharing	In this example, Mia would pay:	Total Example Cost
\$2,000	\$0		\$200	\$300	\$1,500			\$2,800

reduce your costs. For more information about the wellness program, please contact: www.floridablue.com 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

Section 1557 Notification: Discrimination is Against the Law

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

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- 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

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

Health and vision coverage (including FEP	Dental, life, and disability coverage:
members):	Civil Rights Coordinator
Section 1557 Coordinator	17500 Chenal Parkway
4800 Deerwood Campus Parkway, DCC 1-7	Little Rock, AR 72223
Jacksonville, FL 32246	1-800-260-0331
1-800-477-3736 x29070	1-800-955-8770 (TTY)
1-800-955-8770 (TTY)	civilrightscoordinator@fclife.com
Fax: 1-904-301-1580	
section1557coordinator@floridablue.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

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

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

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

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. 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. share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

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



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

	If you have a test		If you visit a health care provider's office or clinic		Common Medical Event
Imaging (CT/PET scans, MRIs)	<u>Diagnostic test</u> (x-ray, blood work)	Preventive care/screening/ immunization	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need
Physician Office: \$300 <u>Copay</u> per Visit/ Independent Diagnostic Testing Center: \$200 <u>Copay</u> per Visit	Value Choice Specialist: \$20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: \$65 Copay per Visit	No Charge, <u>Deductible</u> does not apply	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$65 Copay per Visit/ Virtual Visits: \$65 Copay per Visit	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	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	III Pay Out-of-Network Provider (You will pay the most)
Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.	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.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for ln-Network providers.	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for ln-Network providers.	Limitations, Exceptions, & Other Important Information

If you have a hospital stay		immediate medical	T Voice page		If you have	ols- resources/pharmac y/medication-guide	available at https://www.floridabl	More information about prescription drug coverage is	If you need drugs to treat your illness or condition	Common Medical Event
Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Specialty drugs	Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Services You May Need
Deductible + 30% Coinsurance	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	Deductible + 30% Coinsurance	Physician Services: <u>Deductible</u> + 30% <u>Coinsurance/</u> Facility: \$300 <u>Copay</u> per Visit	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Specialty drugs are subject to the cost share based on applicable drug tier.	\$50 <u>Copay</u> per Prescription at retail, \$125 <u>Copay</u> per Prescription by mail	\$30 <u>Copay</u> per Prescription at retail, \$75 <u>Copay</u> per Prescription by mail	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Not Covered	Not Covered	In-Network Deductible + 30% Coinsurance	Physician Services: In- Network Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	III Pay Out-of-Network Provider (You will pay the most)
Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your	Out-of-Network only covered out-of-state.	Out-of-Network only covered for emergencies.	none	none	Prior Authorization may be required. Your benefits/services may be denied.	Up to 30 day supply for retail. Not covered through Mail Order.	Up to 30 day supply for retail, 90 day supply for mail order.	Up to 30 day supply for retail, 90 day supply for mail order.	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.	Limitations, Exceptions, & Other Important Information

		other special health needs	recovering or have	If you need help			If you are pregnant		services	If you need mental health, behavioral health, or			Common Medical Event
Hospice services	Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services	Outpatient services	Physician/surgeon fees		Services You May Need
Deductible + 30% Coinsurance	Motorized Wheelchairs: \$500 Copay/ All Other: No Charge, Deductible does not apply	Deductible + 30% Coinsurance	Not Covered	\$65 <u>Copay</u> per Visit	No Charge, <u>Deductible</u> does not apply	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	\$65 <u>Copay</u> on initial Visit	No Charge, <u>Deductible</u> does not apply	No Charge, <u>Deductible</u> does not apply	Deductible + 30% Coinsurance		What You Will Pay Network Provider (You will pay the least) (You will pay the least)
Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered		Vill Pay Out-of-Network Provider (You will pay the most)
Prior Authorization may be required. Your	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age. Prior Authorization may be required. Your benefits/services may be denied.	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.	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.	Coverage limited to 60 visits.	none	none	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	Prior Authorization may be required. Your benefits/services may be denied.	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.	none-	benefits/services may be denied.	Limitations, Exceptions, & Other Important Information

Common		What You Will Pay	Will Pay	Limitations Exceptions & Other Important
Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Information
michigal Excit		(You will pay the least)	(You will pay the most)	information
				benefits/services may be denied.
If your child peode	Children's eye exam	Not Covered	Not Covered	Not Covered
dental or eve care	Children's glasses	Not Covered	Not Covered	Not Covered
aciliai oi cyc calc	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

•	•	•	•	•	•	Se
Hearing aids	Habilitation services	Dental care (Adult)	Cosmetic surgery	Bariatric surgery	Acupuncture	Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
•	•		•	•	•	eck y
Pediatric eye exam	Pediatric dental check-up	U.S.	Non-emergency care when traveling outside the	Long-term care	Infertility treatment	our policy or plan document for more information
	•	•	•	•	•	on an
	Weight loss programs	Routine foot care unless for treatment of diabetes	Routine eye care (Adult)	Private-duty nursing	Pediatric glasses	d a list of any other excluded services.)

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	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please
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Chiropractic care - Limited to 30 visits Most coverage provided outside the United States. See www.floridablue.com.

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 Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance 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 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

of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform 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 department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may 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 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 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 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, 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

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provide
nis <u>plan</u> provide <u>Minimum Essential Co</u>
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.

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	Does this <u>plan</u> meet the <u>Minimum Val</u> ı
	n Valu
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)	tand
	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 <u>plan</u> might cover costs for a sample medical situation, see the next section:

About these Coverage Examples:



costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage. amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be

Peg is Having a Baby (9 months of <u>in-network</u> 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

Other No Charge

Specialist Copayment

Hospital (facility) Coinsurance

\$65 30%

Specialist Copayment

The plan's overall deductible

\$1,500

Hospital (facility) Coinsurance

\$65 30%

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

<u>(in-network emergency room visit and follow up</u>

care)

Mia's Simple Fracture

ā	1
e plan's	
overall	COLLEG
s overall deductible	controlled condition,
\$1,500	

This EXAMPLE event includes services like: Specialist office visits (prenatal care)

Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

In this example, Peg would pay:

Cost Sharing

Total Example Cost

Limits or exclusions

What isn't covered

The total Peg would pay is

Coinsurance

Copayments

Deductibles

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)

This EXAMPLE event includes services like: Emergency room care (including medical

Other Copayment

supplies)

<u>Diagnostic test</u> (x-ray)

Durable medical equipment (c

<u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)

In this example, Mia would pay:

Cost Sharing

\$1,500

\$600

\$60

Total Example Cost

\$2,800

\$12,700 \$1,500 \$2,100 \$3,740 \$60 \$80 In this example, Joe would pay: Limits or exclusions Coinsurance Deductibles **Total Example Cost** The total Joe would pay Copayments What isn't covered Cost Sharing \$1,500 \$5,600 \$0 \$0

\$2,160	The total Mia would pay is	\$1,500	yis
	Limits or exclusions	\$0	
	What isn't covered		i covered

Deductibles Copayments Coinsurance

reduce your costs. For more information about the wellness program, please contact: www.floridablue.com. 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

7 of 7

Section 1557 Notification: Discrimination is Against the Law

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

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

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

section1557coordinator@floridablue.com	Fax: 1-904-301-1580	1-800-955-8770 (TTY)	1-800-477-3736 x29070	Jacksonville, FL 32246	4800 Deerwood Campus Parkway, DCC 1-7	Section 1557 Coordinator	members):	Health and vision coverage (including FEP
		civilrightscoordinator@fclife.com	1-800-955-8770 (TTY)	1-800-260-0331	Little Rock, AR 72223	17500 Chenal Parkway	Civil Rights Coordinator	Dental, life, and disability coverage:

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