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Professional Armed and Unarmed Security Officers since 1982.

Open Enrollment for Health Insurance for 2026

Open enrollment for health insurance coverage that will begin 1/1/2026 will be from 11/12/2025-11/26/2025.

To be eligible employees must work a minimum of 30 hours every week on a permanent schedule 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 being offered at this time is for HEALTH only. If you wish to sign up you must fill out the attached application and submit to the office by the end of enrollment. Those wishing to decline coverage please respond accordingly on the EHUB notification. Those currently enrolled 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 price changes in the plans) If you wish to change plans please contact us for a change form.

Attached you will find 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 1/1/26 will be 12/16/25.

If emailing questions, applications, declining coverage or change request forms you can email

Amy - akoon@giddenssecurity.com

Or

Anita - aescalona@giddenssecurity.com



Please type or write clearly in black or blue ink.

Group Name:		Group #:		Division #:		Package #:	
Effective Date of Coverage:		Date of Hire:		Location #:		Employee #:	
						Job Title:	
Work Status:		Retirement Date:		Paid:		Open Enrollment	
☐ Actively at Work ☐ Cobra ☐ Retired				☐ Hourly ☐ Salary		☐	

Social Security #:	Last Name:	First Name:	M.I.: Birth Date:	Sex: ☐ M ☐ F
Street Address:		Apt. #: City:	State: Zip:	
County:	Phone:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		
Physician Name / ID # HMO only:	Existing Patient: ☐ Yes ☐ No	Language of Preference: optional - for data collection purposes only ☐ English ☐ Spanish ☐ Other ☐ Prefer not to answer		

Section C: Health Coverage Level and Plan Information

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

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

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

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

Vision Plan Choice:

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

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

Last Name: <i>(if different than employee)</i> First Name, M.I.		Social Security Number:	Birth Date:	Relation to You						Physician Name/ID <i>HMO only</i>	Existing Patient (Y/N)	You Support	Lives With You	Is a Student	Ethnicity optional
				Spouse (S)	Child (C)	Domestic Partner (DP)	Domestic Part. Child (DPC)	Other (O)*	Health						Vision
											☐	☐			A B C H N W
											☐	☐			A B C H N W
											☐	☐			A B C H N W
											☐	☐			A B C H N W

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

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

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

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

Florida Blue and/or Truli for Health Contract # _____

Medicare # _____

Pharmacy/Medicare D # _____

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

Prior Health Carrier Name: _____

Contract #: _____

Effective Date: _____

Prior Employee Hire Date: _____

Cancel Date: _____

List names of all family members that were covered, including yourself: _____

Signature: _____

Date: _____

Section G: Acceptance of Coverage

Plan Coverage Terms

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

I authorize my employer to deduct from my earnings my premium contribution, if any. I understand all of the following:

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

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

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

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

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

General Terms

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

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

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

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

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

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

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

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

Signature: _____

Date: _____

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

GIDDENS SECURITY CORP 2026

Plan Name:	05907 BlueOptions	05302 BlueOptions	03900 BlueOptions	52 BlueCare HMO
Carrier:	Florida Blue - Large Group	Florida Blue - Large Group	Florida Blue - Large Group	Florida Blue - Large Group

PLAN FEATURES

Deductible Ind / Fam	\$7,500 / \$15,000	\$5,000 / \$10,000	\$1,500 / N/A	\$1,500 Per Person
Coinsurance	20%	30%	50%	30%
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	\$8,200 / \$16,400	\$6,350 / \$12,700	\$6,950 / \$13,600	\$6,350 / \$12,700
Wellness / Preventive Care	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay

PHYSICIAN SERVICES

PCP Office Copay	\$0 COPAY up to 3 visits then \$30 Copay	\$30 Copay	\$35 Copay	\$40 Copay
Specialist Office Copay	Specialist: \$60 Copay	\$55 Copay	\$50 Copay	\$65 Copay

HOSPITAL CARE

Inpatient Hospital Facility Fee	20% after DED	30% after DED	Option 1: \$1,500 Copay	30% after DED
Hospital Physician Services	20% after DED	30% after DED	Ded + 50%	30% after DED
Outpatient Diagnostic Testing	Lab: \$0 Copay; X-Ray: \$60 Copay; Advanced Imaging: 20% after DED	Lab: \$0 Copay; X-Ray & Advanced Imaging: 30% after DED	Lab: \$0 Copay; X-Ray: \$0 or \$20, 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 Ded+30% Surg Center \$300 Copay	30% after DED

EMERGENCY MEDICAL CARE

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

PHARMACY - PRESCRIPTION DRUG BENEFIT

Deductible	N/A	N/A	N/A	N/A
Prescription Drug Benefit	Generic: \$10 Copay	Generic: \$10 Copay	Generic: \$10 Copay	Generic: \$10 Copay
	Preferred Brands: 20% up to a max of \$200 per prescription	Preferred Brands: 20% up to a max of \$200 per prescription	Preferred Brands: 20% up to a max of \$200 per prescription	Brand: \$30 Copay
	Non-Preferred: Not Covered	Non-Preferred: Not Covered	Non-Preferred: Not Covered	Non-Preferred: \$50 Copay

OUT-OF-NETWORK EMERGENCY COVERAGE ONLY

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

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

Member Tier	Employee Bi-Weekly Rates			
Employee Only	\$101.57	\$136.05	\$135.33	\$203.81
Employee + Spouse	\$600.47	\$679.07	\$677.44	\$833.94
Employee + Child	\$491.34	\$560.28	\$558.85	\$696.14
Family	\$959.06	\$1,069.36	\$1,067.08	\$1,286.74



BlueOptions 03900

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

Coverage Period: 01/01/2026 - 12/31/2026

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

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



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,500 Per Person. Out-of-Network: \$4,500 Per Person.	Generally, you must pay all of the costs from <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 deductible 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 deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost sharing</u> and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$6,950 Per Person/ \$13,600 Family. Out-Of-Network: \$20,000 Per Person/ \$20,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/pr providersearch/pub/index.htm or call 1-800-352-2583 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an out-of-network provider for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	\$10 Copay per Prescription at retail, \$25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.
	Preferred brand drugs	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: \$300 Copay per Visit/ Hospital: Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	_____none_____
	Physician/surgeon fees	Ambulatory Surgical Center: \$100 Copay per Visit/ Hospital: Deductible + 50% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 50% Coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	_____none_____
	Emergency medical transportation	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	_____none_____
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2; Deductible + 50% Coinsurance per remaining Visit/ Urgent Care Visits:	Deductible + 50% Coinsurance	_____none_____

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Inpatient Rehab Services limited to 30 days. _____none_____
	Physician/surgeon fees	<u>Deductible + 50% Coinsurance</u>	<u>In-Network Deductible + 50% Coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Specialist Virtual Visits: \$50 Copay per Visit/ Physician Office: \$50 Copay per Visit / Hospital: <u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance/ Specialist Virtual Visits: Not Covered</u>	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	Physician Services: No Charge, Deductible does not apply / Hospital: \$1,500 Copay per Admission	Physician Services: No Charge, Deductible does not apply/ Hospital: <u>Deductible + 50% Coinsurance</u>	
If you are pregnant	Office visits	\$50 Copay on initial Visit	<u>Deductible + 50% Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) _____none_____
	Childbirth/delivery professional services Childbirth/delivery facility services	<u>Deductible + 50% Coinsurance</u> \$1,500 Copay per Admission	<u>In-Network Deductible + 50% Coinsurance</u> <u>Deductible + 50% Coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	<u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 45 visits.
	Rehabilitation services	\$50 Copay per Visit	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 40 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	<u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 60 days.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	<u>Durable medical equipment</u>	<u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	<u>Deductible + 50% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	_____none_____
	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
<u>Excluded Services & Other Covered Services:</u>		Children's dental check-up	Not Covered	Not Covered

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	• Infertility treatment	• Pediatric glasses
• Bariatric surgery	• Long-term care	• Private-duty nursing
• Cosmetic surgery	• Non-preferred brand drugs	• Routine eye care (Adult)
• Dental care (Adult)	• Pediatric dental check-up	• Routine foot care unless for treatment of diabetes
• Habilitation services	• Pediatric eye exam	• Weight loss programs
• Hearing aids		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Chiropractic care - Limited to 40 visits	• Most coverage provided outside the United States. See www.floridablue.com .	• Non-emergency care when traveling outside the U.S.
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits

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

Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section. _____

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



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

Peg is Having a Baby

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

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

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$1,600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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.

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

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

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

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

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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:

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

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

Coverage Period: 01/01/2026 - 12/31/2026

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

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



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$5,000 Per Person/ \$10,000 Family. Out-of-Network: \$10,000 Per Person/ \$30,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$6,350 Per Person/ \$12,700 Family. Out-Of-Network: \$20,000 Per Person/ \$40,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>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 network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the <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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	\$10 Copay per Prescription at retail, \$25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.
	Preferred brand drugs	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	_____none_____
	Physician/surgeon fees	Ambulatory Surgical Center: \$100 Copay per Visit/ Hospital: Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	Physician Services: Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit	Physician Services: In-Network Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit	_____none_____
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	_____none_____
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2,\$60 Copay per	Deductible + \$60 Copay per Visit	_____none_____

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	remaining Visit/ Urgent Care Visits: \$60 Copay per Visit		
	Physician/surgeon fees	<u>Deductible + 30% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Inpatient Rehab Services limited to 30 days.
If you need mental health, behavioral health, or substance abuse services		<u>Deductible + 30% Coinsurance</u>	<u>In-Network Deductible + 30% Coinsurance</u>	_____none_____
	Outpatient services	Specialist Virtual Visits: \$55 Copay per Visit/ Physician Office: \$55 Copay per Visit / Hospital: <u>Deductible + 30% Coinsurance</u>	<u>Deductible + 50% Coinsurance/ Specialist Virtual Visits: Not Covered</u>	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	Physician Services: No Charge, Deductible does not apply / Hospital: <u>Deductible + 30% Coinsurance</u>	<u>Physician Services: No Charge, Deductible does not apply/ Hospital: Deductible + 50% Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$55 Copay on initial Visit	<u>Deductible + 50% Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible + 30% Coinsurance</u>	<u>In-Network Deductible + 30% Coinsurance</u>	_____none_____
	Childbirth/delivery facility services	<u>Deductible + 30% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	_____none_____
If you need help recovering or have other special health needs	Home health care	<u>Deductible + 30% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 45 visits.
	Rehabilitation services	\$55 Copay per Visit	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 40 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	<u>Deductible + 30% Coinsurance</u>	<u>Deductible + 50% Coinsurance</u>	Coverage limited to 60 days.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Deductible + 30% Coinsurance	Coinurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	_____none_____
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
Chiropractic care - Limited to 40 visits	- Most coverage provided outside the United States. See www.floridablue.com. - Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance,

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

contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section. _____

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- The plan's overall deductible \$5,000
- Specialist Copayment \$55
- Hospital (facility) Coinsurance 30%
- Other No Charge \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$70
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,130

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.

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

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

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance services to people whose primary language is not English, such as:
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 - 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 (FEP): 1-800-333-2227
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP

members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:

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

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

HMO

Coverage Period: 01/01/2026 - 12/31/2026

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

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



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,500 Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$6,350 Per Person/ \$12,700 Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: \$40 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Specialist</u> visit	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Specialist: \$65 <u>Copay</u> per Visit/ Virtual Visits: \$65 <u>Copay</u> per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Preventive care/screening/immunization</u>	No Charge, <u>Deductible</u> does not apply	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't <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.
If you have a <u>test</u>	<u>Diagnostic test</u> (x-ray, blood work)	Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$65 <u>Copay</u> per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Physician Office: \$300 <u>Copay</u> per Visit/ Independent Diagnostic Testing Center: \$200 <u>Copay</u> per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.
	Preferred brand drugs	\$30 <u>Copay</u> per Prescription at retail, \$75 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	\$50 <u>Copay</u> per Prescription at retail, \$125 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible + 30% Coinsurance</u>	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Ambulatory Surgical Center: \$100 <u>Copay</u> per Visit/ Hospital: <u>Deductible + 30% Coinsurance</u>	Not Covered	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	Physician Services: <u>Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit</u>	Physician Services: <u>In-Network Deductible + 30% Coinsurance/ Facility: \$300 Copay per Visit</u>	_____none_____
	<u>Emergency medical transportation</u>	<u>Deductible + 30% Coinsurance</u>	<u>In-Network Deductible + 30% Coinsurance</u>	<u>Out-of-Network only covered for emergencies.</u>
	<u>Urgent care</u>	Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2,\$85 <u>Copay</u> per remaining Visit/ Urgent Care Visits: \$85 <u>Copay</u> per Visit	Not Covered	<u>Out-of-Network only covered out-of-state.</u>

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible + 30% Coinsurance</u>	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied. _____none_____
	Physician/surgeon fees	<u>Deductible + 30% Coinsurance</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Specialist Virtual Visits: No Charge, <u>Deductible</u> does not apply/ Physician Office: \$40 Copay per Visit / Hospital: <u>Deductible + 30% Coinsurance</u>	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	<u>Deductible + 30% Coinsurance</u>	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	\$65 <u>Copay</u> on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	<u>Deductible + 30% Coinsurance</u>	Not Covered	_____none_____
	Childbirth/delivery facility services	<u>Deductible + 30% Coinsurance</u>	Not Covered	_____none_____
	Home health care	No Charge, <u>Deductible</u> does not apply	Not Covered	Coverage limited to 60 visits.
If you need help recovering or have other special health needs	Rehabilitation services	\$65 <u>Copay</u> per Visit	Not Covered	Coverage limited to 45 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	<u>Deductible + 30% Coinsurance</u>	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Motorized Wheelchairs: \$500 <u>Copay</u> / All Other: No Charge, <u>Deductible</u> does not apply	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to usage. Prior

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Deductible + 30% Coinsurance	Not Covered	Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
Chiropractic care - Limited to 45 visits	Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section. _____

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- The plan's overall deductible \$1,500
- Specialist Copayment \$65
- Hospital (facility) Coinsurance 30%
- Other No Charge \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$80
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,740

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.

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist Copayment \$65
- Hospital (facility) Coinsurance 30%
- Other No Charge \$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

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

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, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability.

We provide:

- Free auxiliary aids, reasonable modifications, and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP

members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:

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

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 05907

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

Coverage Period: 01/01/2026 - 12/31/2026

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

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



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$7,500 Per Person/ \$15,000 Family. Out-Of-Network: \$15,000 Per Person/ \$30,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$8,200 Per Person/ \$16,400 Family. Out-Of-Network: \$16,400 Per Person/ \$32,800 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: No Charge, <u>Deductible</u> does not apply - Visits 1-3;\$30 Copay per remaining Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Specialist</u> visit	Value Choice Specialist: \$20 Copay per Visit/ Specialist: \$60 Copay per Visit/ Virtual Visits: \$60 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.
	<u>Preventive care/screening/immunization</u>	No Charge, <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Physician administered drugs may have higher cost share. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	Value Choice Specialist: \$20 Copay per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$60 Copay per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share.
If you have a test	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	\$10 Copay per Prescription at retail, \$25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication Guide for more information.
	Preferred brand drugs	20% Coinsurance up to a maximum of \$200 per Prescription at retail, 20% Coinsurance up to a maximum of \$500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	_____none_____
	Physician/surgeon fees	Ambulatory Surgical Center: \$100 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	_____none_____
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	_____none_____
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2: \$100 Copay per remaining Visit/ Urgent Care Visits: \$100 Copay per Visit	Deductible + \$100 Copay per Visit	_____none_____
If you have a	Facility fee (e.g., hospital)	Deductible + 20% Coinsurance	Deductible + 50%	Inpatient Rehab Services limited to 30 days.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
hospital stay	room)		Coinsurance	
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Specialist Virtual Visits: \$60 Copay per Visit/ Physician Office: \$60 Copay per Visit / Hospital: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are <u>only</u> covered for In-Network providers.
	Inpatient services	Physician Services: No Charge, Deductible does not apply / Hospital: Deductible + 20% Coinsurance	Physician Services: No Charge, Deductible does not apply/ Hospital: Deductible + 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	\$60 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	_____none_____
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	_____none_____
	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 45 visits.
If you need help recovering or have other special health needs	Rehabilitation services	\$60 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 40 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	and replacement of DME due to use/age. _____none_____
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
Chiropractic care - Limited to 40 visits	- Most coverage provided outside the United States. See www.floridablue.com. - Non-emergency care when traveling outside the U.S.

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also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section. _____

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Peg is Having a Baby

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

- The plan's overall deductible \$7,500
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 20%
- Other No Charge \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$7,500
Copayments	\$70
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,830

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.

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$7,500
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 20%
- Other Coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

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

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$7,500
- Specialist Copayment \$60
- Hospital (facility) Coinsurance 20%
- Other Coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

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

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 - Qualified sign language interpreters
 - Written information in other formats (e.g., large print, audio, and accessible electronic formats)
- Free language assistance 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 (FEP): 1-800-333-2227
- Medicare: 1-800-926-6565
- TTY 711

If you believe that we have failed to provide these services or have discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with:

Health and vision coverage (including FEP

members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557Coordinator@bcbsfl.com

Dental, life, and disability coverage:

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

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.