
 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 at www.725benefits.org. 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.healthcare.gov/sbc-glossary or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$500 Per Person/\$1,500 Family. <u>Out-of-Network</u> : Combined with In-Network .	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$300 <u>Out-of-Network</u> Per Hospital Admission <u>Deductible</u> . \$300 <u>In-Network</u> / \$300 <u>Out-of-Network</u> per ER Visit. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. <u>In-Network</u> : \$4,500 Per Person/\$9,000 Family. <u>Out-Of-Network</u> : 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</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-664-5295 for a list of <u>network providers</u> .	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 charge</u> 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 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	Primary Care Visits: \$45 <u>Copay</u> per Visit/ Virtual Visits (Telemedicine) \$45 <u>Copay</u> per Visit	Primary Care Visits: <u>Deductible</u> + 40% <u>Coinsurance</u> / Virtual Visits: (Telemedicine) Not Covered	Virtual Visit services are only covered for In-Network providers.
	<u>Specialist</u> visit	Specialist: <u>Deductible</u> + 20% <u>Coinsurance</u> / Virtual Visits: (Telemedicine) <u>Deductible</u> + 20% <u>Coinsurance</u>	Specialist: <u>Deductible</u> + 40% <u>Coinsurance</u> / Virtual Visits: (Telemedicine) Not Covered	Virtual Visit services are only covered for In-Network providers.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: 20% <u>Coinsurance</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	Independent Clinical Lab: 40% <u>Coinsurance</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 40% <u>Coinsurance</u>	Prior authorization may be required for certain procedures. Failure to obtain prior coverage authorization may result in denial of coverage for such Services.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.floridablue.com/members/tols-resources/pharmacy/medication-guide	Generic drugs	\$15 <u>Copay</u> per Prescription at retail, \$30 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	Up to 30-day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information.
	Preferred brand drugs	\$35 <u>Copay</u> per Prescription at retail, \$70 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	
	Non-preferred brand drugs	\$65 <u>Copay</u> per Prescription at retail, \$130 <u>Copay</u> per Prescription by mail	50% <u>Coinsurance</u>	
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30-day supply for retail. Responsible Rx programs such as Prior Authorization may apply. Failure to obtain prior coverage authorization may result in denial of coverage for such Services. See Medication guide for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 40% <u>Coinsurance</u> / Hospital: <u>Deductible</u> + 20% <u>Coinsurance</u>	————none————
If you need immediate medical attention	<u>Emergency room care</u>	Per Visit <u>Deductible</u> + 20% <u>Coinsurance</u>	Per Visit <u>Deductible</u> + 20% <u>Coinsurance</u>	————none————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	————none————
	<u>Urgent care</u>	\$45 <u>Copay</u> per Visit	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————

For more information about limitations and exceptions, see the [plan](#) or policy document at www.725benefits.org

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</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Failure to obtain prior coverage authorization may result in denial of coverage for such Services.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Not Covered	Not Covered	—————none—————
	Inpatient Services	Not Covered	Not Covered	—————none—————
If you are pregnant	Office visits	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
	Childbirth/delivery facility services	<u>Deductible</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	—————none—————
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	—————none—————
	<u>Rehabilitation services</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Occupational Therapy is Not Covered
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered

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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)	
	<u>Skilled nursing care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>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</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	—————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	0% Coinsurance plus amounts over allowed charges	Coverage is through Florida Combined Life and is limited to 2 visits and \$2,500 in any Contract Year

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Habilitation services 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Mental health/behavioral health and substance abuse • Pediatric eye exam 	<ul style="list-style-type: none"> • Pediatric glasses • Private-duty nursing • Routine eye care (Adult) • Routine foot care unless for treatment of diabetes • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Chiropractic care • Dental care (Adult/Child) through Florida Combined Life 	<ul style="list-style-type: none"> • For any questions regarding dental benefits, or if you desire to appeal a denial of coverage of any dental claim, please contact Florida Combined Life at 1-888-223-4892 or visit its website at www.floridabluedental.com. 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.floridablue.com • Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

For more information about limitations and exceptions, see the plan or policy document at www.725benefits.org

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/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.

***No Surprises Act:** Effective January 1, 2022, the "No Surprises Act" enacted by Congress will cap your cost-sharing obligation for out-of-network (OON) claims to the applicable in-network cost-sharing level for the following services: (1) emergency services performed by an OON provider or facility and post-stabilization care if you cannot be moved to an in-network facility; (2) non-emergency services provided by an OON provider at in-network facilities, including hospital and ambulatory surgical centers (such services may include off-site lab, imaging, or other services associated with the visit to the in-network facility); and (3) air ambulance services provided by OON providers. These caps are intended to protect you from balance-billing or "surprise billing" by OON providers

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.725benefits.org

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** \$500
- **Specialist Coinsurance** 20%
- **Hospital (facility) Coinsurance** 20%
- **Other Coinsurance** 20%

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:

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

- **The plan's overall deductible** \$500
- **Specialist Coinsurance** 20%
- **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:

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

- **The plan's overall deductible** \$500
- **Specialist Coinsurance** 20%
- **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:

The plan would be responsible for other costs of these EXAMPLE covered services.

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,020

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,900
<u>Coinsurance</u>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,510

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$420
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,120

