### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**

| In-Network: $1,400 Per Person. Out-of-Network: $2,800 Per Person. |

Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

**Are there services covered before you meet your deductible?**

| Yes. Preventive care. |

This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://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?**

| Yes. In-Network: $5,000 Per Person. Out-Of-Network: $10,000 Per Person. |

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, the overall family out-of-pocket limit must be 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](http://https://providersearch.floridablue.com/providersearch/pub/index.htm) or call 1-800-664-5295 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Physician administered drugs may have higher cost shares.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Physician administered drugs may have higher cost shares.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% Coinsurance</td>
<td>Physician administered drugs may have higher cost shares. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Tests performed in hospitals may have higher cost-share.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.floridablue.com/tools-resources/pharmacy/medication-guide">www.floridablue.com/tools-resources/pharmacy/medication-guide</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Deductible + $7 Copay per Prescription at retail, Deductible + $14 Copay per Prescription by mail</td>
<td>Not Covered</td>
<td>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.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Deductible + $25 Copay + 10% Coinsurance per Prescription at retail, Deductible + $50 Copay + 10% Coinsurance per Prescription by mail</td>
<td>Not Covered</td>
<td>Up to 30 day supply for retail, 90 day supply for mail order.</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Deductible + $40 Copay + 10% Coinsurance per Prescription at retail, Deductible + $80 Copay + 10% Coinsurance per Prescription by mail</td>
<td>Not Covered</td>
<td>Up to 30 day supply for retail, 90 day supply for mail order.</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com.
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<tr>
<td></td>
<td>Specialty drugs</td>
<td>Self-Administered Specialty drugs $55 Copay per Prescription + 10% Coinsurance. All other specialty drugs are subject to the cost share based on applicable drug tier.</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Ambulatory Surgical Center: Deductible + 20% Coinsurance/ Hospital: Deductible + 25% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible + 20% Coinsurance</td>
<td>Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Emergency room care</td>
<td>Deductible + 25% Coinsurance</td>
<td>In-Network Deductible + 25% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Deductible + 20% Coinsurance</td>
<td>In-Network Deductible + 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 20% Coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible + 25% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible + 20% Coinsurance</td>
<td>In-Network Deductible + 20% Coinsurance</td>
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<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td><strong>Network Provider</strong>&lt;br&gt;(You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network Provider</strong>&lt;br&gt;(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician Office: Deductible + 20% Coinsurance / Hospital</td>
<td>Deductible + 50% Coinsurance</td>
<td>Option 2 hospitals may have a higher cost-share.</td>
</tr>
<tr>
<td></td>
<td>Physician Services: Deductible + 20% Coinsurance / Hospital</td>
<td>Deductible + 50% Coinsurance</td>
<td>Prior Authorization may be required. Your benefits/services may be denied. Option 2 hospitals may have a higher cost-share.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Deductible + 20% Coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Deductible + 20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Deductible + 25% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Deductible + 20% Coinsurance</td>
<td>Coverage limited to 80 visits.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Coverage limited to 80 Outpatient therapy and manipulations, excluding Massage therapy. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Coverage limited to 120 days.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td>Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
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For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com](http://www.floridablue.com).
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<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>dental or eye care</td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Chiropractic care
- Hearing aids
- Infertility treatment
- Long-term care
- 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

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
- Chiropractic care
- Hearing aids
- Infertility treatment
- Long-term care
- 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
- 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/ebsa/healthreform 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 1-800-664-5295. 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/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com.
Does this plan meet 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.
### 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.

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Plan Details</th>
<th>Cost Sharing</th>
<th>What isn't covered</th>
</tr>
</thead>
</table>
| **Peg is Having a Baby** (9 months of in-network pre-natal care and a hospital delivery) | - The plan’s overall deductible: $1,350  
  - Specialist Coinsurance: 20%  
  - Hospital (facility) Coinsurance: 25%  
  - Other: No Charge  
  | Total Example Cost: $12,800 | Deductibles: $1,350  
  Copayments: $30  
  Coinsurance: $2,500  
  | Limits or exclusions: $60  
  The total Peg would pay is: $3,940  
  | 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)  
  |  
| **Managing Joe’s type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) | - The plan’s overall deductible: $1,350  
  - Specialist Coinsurance: 20%  
  - Hospital (facility) Coinsurance: 25%  
  - Other: No Charge  
  | Total Example Cost: $7,400 | Deductibles: $1,350  
  Copayments: $1,000  
  Coinsurance: $500  
  | Limits or exclusions: $60  
  The total Joe would pay is: $2,910  
  | 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)  
  |  
| **Mia’s Simple Fracture** (in-network emergency room visit and follow up care) | - The plan’s overall deductible: $1,350  
  - Specialist Coinsurance: 20%  
  - Hospital (facility) Coinsurance: 25%  
  - Other: No Charge  
  | Total Example Cost: $1,900 | Deductibles: $1,350  
  Copayments: $0  
  Coinsurance: $100  
  | Limits or exclusions: $0  
  The total Mia would pay is: $1,450  
  | This EXAMPLE event includes services like:  
  Emergency room care (including medical supplies)  
  Diagnostic test (x-ray)  
  Durable medical equipment (crutches)  
  Rehabilitation services (physical therapy)  
  |

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](http://www.floridablue.com).
Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, “Florida Blue”), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-664-5295
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

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

**Florida Blue (including FEP members):**

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

**Florida Combined Life:**

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@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.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201
1-800-368-1019  
1-800-537-7697 (TDD)  
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html


ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-664-5295 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-664-5295（TTY: 1-800-955-8770）。FEP：請致電1-800-333-2227


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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.
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.