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](https://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](https://www.floridablue.com/plancontracts/group) or call 1-800-352-2583 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $5,000 Per Person/$10,000 Family. Out-of-Network: Not Applicable.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Yes. In-Network: $6,350 Per Person/$12,700 Family. Out-Of-Network: $10,000 Per Person/$20,000 Family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, balance-billed charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://providersearch.floridablue.com/providersearch/pub/index.htm">https://providersearch.floridablue.com/providersearch/pub/index.htm</a> or call 1-800-352-2583 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.
<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><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs</td>
<td>Specialty drugs are subject to the cost share based on applicable drug tier.</td>
<td>Specialty drugs are subject to the cost share based on the applicable drug tier.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible + 30% Coinsurance</td>
<td>Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No Charge</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>Physician Services: No Charge/ Hospital: 50% Coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$50 Copay per Visit</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
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</tr>
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<td></td>
<td></td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 Copay per Visit</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Deductible + 30% Coinsurance</td>
<td>Deductible + 50% Coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></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:**

**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
- 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 35 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/ebса/healthreform 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.floridablue.com/plancontracts/group.
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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Specialist Copayment</td>
<td>Specialist Copayment</td>
<td>Specialist Copayment</td>
</tr>
<tr>
<td>$50</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital (facility) Coinsurance</td>
<td>Hospital (facility) Coinsurance</td>
<td>Hospital (facility) Coinsurance</td>
</tr>
<tr>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Other No Charge</td>
<td>Other Coinsurance</td>
<td>Other Coinsurance</td>
</tr>
<tr>
<td>$0</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

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 $12,800

In this example, Peg would pay:

- Cost Sharing
  - Deductibles $5,000
  - Copayments $0
  - Coinsurance $1,400

What isn’t covered
- Limits or exclusions $60

The total Peg would pay is $6,460

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 $7,400

In this example, Joe would pay:

- Cost Sharing
  - Deductibles $0
  - Copayments $2,500
  - Coinsurance $0

What isn’t covered
- Limits or exclusions $60

The total Joe would pay is $2,560

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 $1,900

In this example, Mia would pay:

- Cost Sharing
  - Deductibles $1,300
  - Copayments $200
  - Coinsurance $0

What isn’t covered
- Limits or exclusions $60

The total Mia would pay is $1,500

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.
Section 1557 Notification: Discrimination is Against the Law

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): 1-800-352-2583
- 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

FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (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1-800-352-2583 （TTY: 1-800-955-8770）。FEP：請致電1-800-333-2227


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