

**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, visit [www.sbac.edu](http://www.sbac.edu) or call Florida Blue for your medical questions at 1-800-352-2583, and Express Scripts for your prescription questions at 1-866-581-5255. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. To view the Glossary call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>In-Network: \$1,500 Per Person/\$4,500 Family. Out-of-Network: Combined with In-Network.</u>	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> .
<b>Are there services covered before you meet your deductible?</b>	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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. <u>\$100 Pharmacy Deductible</u> ; There are no other specific deductibles.	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.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. <u>In-Network: \$4,000 Per Person/\$8,000 Family. Out-Of-Network: Combined with In-Network.</u>	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	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 <u>network providers</u> . For a list of participating pharmacies see <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-866-581-5255.	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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care <u>provider's office</u> or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>Copay</u> per Visit	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share. Prior Authorization may be

For more information about limitations and exceptions, see the plan or policy document by calling Florida Blue at 1-800-352-2583 or [www.floridablue.com](http://www.floridablue.com) or call Express Scripts at 1-866-581-5255 or [www.express-scripts.com](http://www.express-scripts.com).

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)	
				required. Your benefits/services may be denied.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at 1-866-581-5255 or <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	20% Coinsurance at retail, \$20 Copay per prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order or Retail 90. Responsible Rx programs such as Prior Authorization may apply.
	Preferred brand drugs	\$100 Pharmacy Deductible + 40% Coinsurance at retail, \$100 Pharmacy Deductible + \$50 Copay per prescription by mail	\$100 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order or Retail 90.
	Non-preferred brand drugs	\$100 Pharmacy Deductible + 40% Coinsurance at retail, \$100 Pharmacy Deductible + \$80 Copay per prescription by mail	\$100 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order or Retail 90.
	<u>Specialty drugs</u>	\$100 Pharmacy Deductible + Retail Coinsurance	\$100 Pharmacy Deductible + 50% Coinsurance	
<b>If you have outpatient surgery</b>	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>In-Network Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	<u>Deductible</u> + \$100 <u>Copay</u> per Visit + 20% <u>Coinsurance</u>	<u>Deductible</u> + \$100 <u>Copay</u> per Visit + 20% <u>Coinsurance</u>	—————none—————

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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>Emergency medical transportation</u>	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————
	<u>Urgent care</u>	\$35 <u>Copay</u> per Visit	<u>Deductible + \$35 Copay</u> per Visit	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	—————none—————
	Inpatient services	<u>Deductible + 20% Coinsurance</u>	Physician Services: <u>Deductible + 20% Coinsurance</u> /Hospital: <u>Deductible + 40% Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
<b>If you are pregnant</b>	Office visits	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————
	Childbirth/delivery facility services	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	—————none—————
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 20 visits.
	<u>Rehabilitation services</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	<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 + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% 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 + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	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 <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"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• <u>Habilitation services</u></li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Pediatric dental check-up</li> <li>• Pediatric eye exam</li> <li>• Pediatric glasses</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care unless for treatment of diabetes</li> <li>• Weight loss programs</li> </ul>

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"> <li>• Chiropractic care - Limited to 35 visits</li> </ul>	<ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.floridablue.com">www.floridablue.com</a>.</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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](http://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](http://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](http://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

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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](http://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](http://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.

**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.*—————

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## 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 <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ Other <u>No Charge</u>	\$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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$700
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,160</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$1,500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,590</b>

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.