Summary of PPO *Benefits*

Benefit Period April **1, 2024** -March 31**, 2025**

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

ICUBA Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Deductible Per Benefit Period (PBP) Individual Family	 $3,000 $6,000	 $4,500 $11,750
Coinsurance	20%	40%
Out-of-Pocket Maximums PBP *(includes deductible, coinsurance, and medical copays)* Individual Family	 $5,000 $10,000	 $8,500 $17,000
Lifetime Maximum	No Maximum	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	$15 copay (not subject to deductible)	40% after deductible
Total Care Physician Office Visit *(Internist, Family Practice, Pediatrician)*	0% (not subject to deductible or copayment)	N/A
Embold Physician Office Visit *(Primary Care, Pediatrician, Cardiology, Obstetrics, Joint care, Spine care, Endocrinology, Gastroenterology, Pulmonology, and Dermatology)*		
Teladoc Telemedicine Visit	0% after $5 copay	N/A
Maternity Office Visit Benefit *(initial OB visit only)*	$15 copay (not subject to deductible)	40% after deductible
Specialist Office Visits	$35 copay (not subject to deductible)	40% after deductible
Independent Clinical Labs ** (free standing facilities and office visits) Outpatient Facility (Hospital setting)***	0% (not subject to deductible) 20% coinsurance	40% after deductible
Preventive Care - Annual Physical and Gynecological exam	0% (not subject to deductible)	Not Covered
Chlamydia and STD tests	0% (not subject to deductible)	Not Covered
PAP tests	0% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	0% (not subject to deductible)	Not Covered
Mammograms and Ultrasounds of the Breast	0% (not subject to deductible)	Not Covered
Urinalysis	0% (not subject to deductible)	Not Covered
Venipuncture/Conveyance Fee	0% (not subject to deductible)	Not Covered
General Health Blood Panel, Glucose Test, Lipid Panel, Cholesterol, and ALT/AST.	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services (e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)	0% (not subject to deductible)	Not Covered

** Quest Diagnostic Labs is the In-Network Lab for BlueCross BlueShield of Florida.

***Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center)

ICUBA Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Allergy Injections	0% (not subject to deductible)	40% after deductible
Emergency Room Services	0% after $500 copay (waived if admitted)	
Medically Necessary Emergency Transportation	0% after $250 copay	
Convenient Care Clinic (Retail) Minute Clinic- CVS/Healthcare Clinic - Walgreens	0% after $10 copay	
Urgent Care Center	0% after $30 copay	
Hospital Expenses		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Outpatient Surgery Office Setting (Physician or Specialist)	20% (not subject to deductible)	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Related professional services	20% after deductible	40% after deductible
Non-Emergent Surgeries with SurgeryPlus Please call 1-855-200-2119 for this separate benefit	*Deductible and coinsurance are waived when utilizing SurgeryPlus services and network*	*Not Covered*
Infertility Services (Counseling and testing to diagnose only)	20% after deductible	40% after deductible
Outpatient Physical Therapy	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Speech Therapy (Restorative services only)	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Occupational Therapy	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Spinal Manipulation	$20 copay (not subject to deductible)	40% after deductible
	Limit: 60 visits/ benefit period	
Diagnostic Services (X-Ray and other tests)	20% after deductible	40% after deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	Allowed Charges up to $500 Copay	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Prosthetic Appliances	20% after deductible	40% after deductible
Hearing Care Services		
Hearing aid screening/exam	20% (not subject to deductible)	
Hearing aid	20% after in-network deductible	
	Combined limit: $1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	20% after deductible	40% after deductible
Inpatient Rehabilitation	20% after deductible	40% after deductible
	Limit: 60 days/ benefit period	
Skilled Nursing Rehabilitation	20% after deductible	40% after deductible
	Limit: 60 days/ benefit period	
Home Health Care	20% after deductible	40% after deductible
Private Duty Nursing	20% after deductible	40% after deductible
Hospice (Inpatient and Outpatient Care)	0% (not subject to deductible)	40% after deductible
Mental Health, Substance Abuse Benefits are provided by Aetna Behavioral Health - Available 24 hours at 877-398-5816		
Mental Health/Substance Abuse		
Inpatient	20% after deductible	40% after deductible
Outpatient	$15 copay (not subject to deductible)	40% after deductible

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. Please see your Plan Document for detailed information on plan terms and the appeals process. Effective 4/1/2024

ATTENTION ICUBA MEMBERS

ICUBA April 1, 2024 – March 31, 2025
Prescription Medication Plan

ICUBA Pharmacy Benefit Prescription Plan Summary

30-Day Supply
Nationwide Pharmacy Network
You have access to more than 62,000 chain and independent pharmacies including: Costco, CVS, Publix Super Markets Inc., Walgreens, Target, The Medicine Shoppe, Walmart, Winn-Dixie Stores, Inc.

90-Day Supply
Convenient Mail Service Pharmacy
Home Delivery is an easy way to receive up to a 90-day supply of your maintenance medication delivered by mail to your door. Standard shipping is free. Orders are shipped in confidential, tamper-evident packaging from Home Delivery pharmacies.

90-Day at Retail Program
This program allows you to obtain a 90-day supply of your maintenance medication at more than 45,000 participating community pharmacies.

Out-of-Pocket Maximum
In-network Rx copays will be applied toward an individual maximum out-of-pocket of $2,000 and $4,000 for family. Once you reach your out-of-pocket maximum, your prescriptions will be paid at 100% by the plan and no cost to you ($0 copay).

Diabetic Supplies
The following prescribed diabetic supplies are covered at 100%, $0 copay: meters, lancets, lancing devices, test strips, control solution, insulin needles and syringes.

Rx with Over-the-Counter (OTC) alternatives
The Rx with OTC strategy excludes certain prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

Over-The-Counter and Generic Preventive Medications
With a prescription from your physician, the following OTC and generic preventive medications are covered as part of your pharmacy benefit with $0 copay: Aspirin for adults, prenatal vitamins or folic acid for women planning or capable of pregnancy, iron supplementation, oral fluoride supplementation for children, vaccines, Vitamin D for adults, bowel preparation agents for colorectal cancer screening, and select statins for prevention of cardiovascular disease (CVD).

Tobacco Cessation
Tobacco cessation medications are covered with $0 copay when you participate in coaching or counseling options though local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling.

Specialty Medications
Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Optum Specialty Pharmacy with BlueCross BlueShield.

MyRx Toolkit and MyHealthToolkit
Find answers by visiting the **MyRx Toolkit** and **MyHealth Toolkit** through the single sign-on section at http://ICUBAbenefits.org to find your lowest copay, manage Home Delivery prescriptions, keep track of your health history and more!

Care Connected in your Corner
If you have a question about your pharmacy benefit, call the Care Connected team toll-free at **(855) 258-9029**, 24 hours a day, 7 days a week.

ICUBAcares Pharmacist Advocate Program

If you have a question about your pharmacy benefit, and would like to speak with a Pharmacist at ICUBAcares, call **(877) 286-3967.**

Copayments	Prescription-Fill Methods*		
Tier	**Retail: Up to a 30-day supply**	***90-Day at Retail Program* Up to a 90-day supply**	**Mail: Up to a 90-day supply**
Low Cost Generics at the Nova Southeast University (NSU) Pharmacy	$0	$0	N/A
Low Cost Generics at all other network pharmacies	$5	$10	$10
Preventive Generics****	$0	$0	$0
Generics: Tier 1 Medications on the Premium Formulary (PF)**	$10	$20	$20
Preferred Brands: Tier 2) Medications on the Premium Formulary	$40	$80	$80
Non-Preferred Brands: Tier 3 Medications Premium Formulary	$75	$150	$150
Preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A
Non-preferred specialty at Optum Specialty Pharmacy	$75***	N/A	N/A

‡ Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.
* Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.
** The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.
*** Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products
**** Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

ICUBA Preferred PPO Plan

Aetna Behavioral Health and Substance Abuse

Aetna Open Choice PPO Network

Plan Year April 1, 2024 through March 31, 2025

Employee Assistance Program (EAP), Mental Health, Substance Abuse Benefits and Applied Behavioral Analysis (ABA) Provided by Aetna Behavioral Health - Available 24/7 - 877-398-5816 Deductibles and Out of Pocket Maximum Amounts are COMBINED with BCBS Medical		
	In Network	**Out of Network**
Employee Assistance Program (EAP) * *Up to 6 short-term professional counseling sessions per episode per year. Talk with a licensed clinician regarding stress, relationship issues, grief, etc.*	**$0**	**No coverage**
Inpatient*	**20% after deductible**	**40% after deductible**
Mental Health Hospital Admission*	**20% after deductible**	**40% after deductible**
Substance Abuse Hospital Admission*	**20% after deductible**	**40% after deductible**
Residential* *Residential Services focus on evaluating and stabilizing the patient. They help the patient learn effective ways to cope with the symptoms and impact of the patient's illness.*	**20% after deductible**	**40% after deductible**
Inpatient Detoxification* *Inpatient detoxification provides 24 hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. Patients typically stay in detoxification only as long as their withdrawal symptoms require 24 hour medical and nursing services.*	**20% after deductible**	**40% after deductible**
Outpatient	**$15 copayment (not subject to deductible)**	**40% after deductible**
Professional Counseling Sessions *Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Psychiatric Medication Evaluation	**$15 copayment (not subject to deductible)**	**40% after deductible**
Applied Behavioral Analysis Therapy* *Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Partial Hospitalization (PHP)* *These programs are longer and more intensive than an IOP, usually 4-6 hours per day, 5-7 days per week. Services include physician and nursing services, as well as group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services. These programs are often used in lieu of an inpatient stay, or as a transition from an inpatient stay.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Outpatient Detoxification *Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
Intensive Outpatient Sessions (IOP) *These planned and structured programs are usually 2-3 hours/day (or evening), and 3-7 days per week. They may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services.*	**$15 copayment (not subject to deductible)**	**40% after deductible**
AbleTo *Meet with a therapist and coach via web-based videoconferencing, or over the telephone for a 8 week program for select conditions including breast and prostate cancer recovery, heart problems, diabetes, depression, digestive health, pain management, respiratory problems, substance abuse, anxiety, postpartum depression, caregiver status (child, elder, Autism, etc.), grief/loss, and military transition.*	**$0**	**No coverage**

**Services require prior-authorization*

aetna®

Resources *for* Living®

Guided Access to Excellent Surgical Care

What is SurgeryPlus?

SurgeryPlus provides you with access to excellent and affordable care for many planned surgical procedures. It's already included in your medical benefits at no additional cost to you.

Did you know...

- There will be no cost for your surgery.

The SurgeryPlus Difference

Excellent Care

Access to our network of thousands of highly qualified surgeons

Impactful Savings

Your surgery will be at little or no cost to you when you use your SurgeryPlus benefit

Guided Support

Your personal Care Advocate will support you every step of the way through your care

Here's what's covered

In partnership with your employer, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your SurgeryPlus benefit. Your coverage includes:

- Consults and appointments with your SurgeryPlus surgeon
- Anesthesia
- Procedure and facility (hospital) fees
- Dedicated support and guidance

Commonly Covered Procedures

- Spine
- Orthopedic
- Ear, Nose & Throat
- Cardiac
- Gynecology
- General Surgery
- Gastrointestinal
- Spine and Ortho Injections
- Bariatrics

Your medical coverage may require you to use your SurgeryPlus benefit for specific procedures. Call to learn more.

You deserve excellent and affordable surgical care.

Call us to learn more at 855.200.2119

Email: ICUBA@SurgeryPlus.com
Website: ICUBA.SurgeryPlus.com

ICUBA

Surgery Plus

virta | ICUBA

Yes. You *can* reverse type 2 diabetes.

In only one year, Virta patients see an average of[1]:

63% medication reduction | **1.3pt** HbA1c reduction | **12%** weight loss

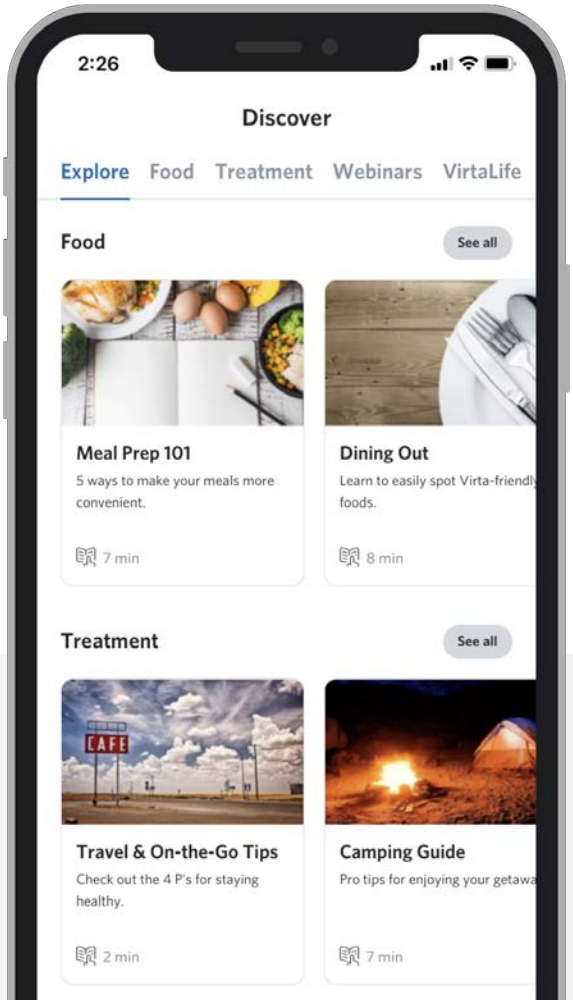
No matter the season or time of year, if you are part of an eligible plan,* you can enroll in Virta. Virta is a research-backed treatment that can help you reverse type 2 diabetes and take back control of your health.

The Virta difference

Unlike other diabetes (or weight loss) treatments/management programs, Virta goes beyond just treating the symptoms of the disease. On Virta, you learn how to change how you eat so that your body burns fat for energy, instead of sugar/carbohydrates. This can help you naturally lower your blood sugar and reduce the need for diabetes medication. It also can help you lose weight and live a healthier life.

ICUBA fully covers the cost of Virta (valued at over $3,000) for you and your eligible family members with type 2 diabetes.

Virta is available to ICUBA members and eligible dependents between the ages of 18 and 79. This benefit is currently being offered to those with type 2 diabetes. There are some medical conditions that would exclude patients from the Virta treatment. Start the application process now to find out if you qualify.



virtahealth.com/join/icuba

Text "VIRTA" to 57005 to receive periodic alerts about diabetes reversal from Virta.

Msg&data may apply. Text HELP for help, STOP to quit.
Privacy Policy: www.virtahealth.com/privacypolicy

1 *Hallberg SJ, McKenzie AL, Williams P, et al. Effectiveness and Safety of a Novel Care Model for the Management of Type 2 Diabetes at One Year: An Open Label, Non-Randomized, Controlled Study. Diabetes Ther. 2018.*

ICUBA | Hinge Health

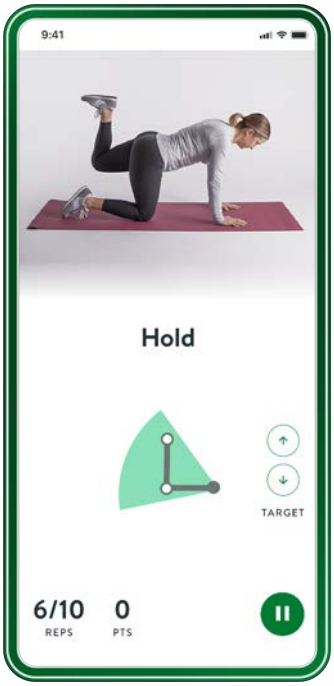
Conquer back and joint pain without drugs or surgery

We provide all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, personal coach and physical therapist. Best of all, **it's free** — 100% covered by ICUBA for you and eligible family members.

Sign up today for help with any of the following:

- **Conquer pain or limited movement**
- **Recover from a past injury**
- **Reduce stiffness in achy joints**

Join for your **back, knee, hip, neck, pelvic, or shoulder or other joint pain**. On average, participants cut their pain as much as 68%*!



Scan the QR code to learn more or apply at
hinge.health/icuba-oe
or call (855) 902-2777

Eligibility: Members and dependents 18+ enrolled in a Blue Cross Blue Shield ICUBA medical plan are eligible.
*Participants with chronic knee and back pain after 12 weeks. Bailey, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. JMIR. (2020).

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 http://icubabenefits.org or by calling 1-866-377-5102. 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 https://www.healthcare.gov/sbc-glossary or www.cciio.cms.gov or call 1-855-258-9029 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 in-network per person; $6,000 family/$4,500 out-of-network per person; $11,750 family.	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. The deductible starts over each April 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Deductible doesn't apply to in-network: preventive care, Teladoc, office visits, prescription drugs, outpatient facility labs, or advanced imaging. Doesn't apply to in- or out-of-network: emergency room, urgent care, convenient care, or emergency transportation.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$5,000 in-network per person; $10,000 family/ $8,500 out-of-network per person/ $17,000 family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	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?	Premiums, balance-billing 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 http://myhealthtoolkitfl.com, contact Essential Advocate at 1-888-521-2583 or call BCBS customer service at 1-855-258-9029 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. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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 (No Deductible)	Primary care visit to treat an injury or illness	$15 Copayment//Visit	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs. Embold Health (Primary Care, Pediatrician, Cardiology, Dermatology, Endocrinology, Joint Care (Orthopedic), Gastroenterology, Neurology, Obstetrics and Gynecology, Podiatry, Pulmonology, and Spine Care (Orthopedic/Neurosurgical). Visits Are Always Free. Therapy and Chiropractic visits are limited to 60 each per Plan Year.
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	$0 Copayment/Visit	Not Applicable	
	Embold Health	$0 Copayment/Visit	Not Covered	
	Specialist visit	$35 Copayment/Visit	Deductible + 40% Coinsurance	
	Convenient Care Clinic	$10 Copayment/Visit	$10 Copayment/Visit	
	Physical/Occupational/Speech Therapy and Chiropractor Visits	$20 Copayment/Visit	Deductible + 40% Coinsurance	
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

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)	
	Diagnostic test (blood work)	$0 for Quest Diagnostic Laboratories; 20% Coinsurance for clinical outpatient facility labs	Deductible + 40% Coinsurance	Must be medically necessary.
If you have a test	X-Ray	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$500 Copay (or actual cost if less) for family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility	Deductible + 40% Coinsurance family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility	Prior Authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MyHealthToolkitFL.com (No Deductible) Out of pocket limit is $2,000 in-network for individual, $4,000 family. No limit for out-of-network.	Preferred Generic drugs	$0 Copay/Prescription (retail 30 and 90-day at NSU pharmacy, NCPDP# 1082041) $5 Copay/Prescription (retail 30-day) $10 Copay/Prescription (retail 90-day) $10 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	Retail 30: 30 day supply; Retail 90: 84-91 day supply; Mail Order: 84–91 day supply Specialty Drugs: Certain medications used for treating complex health conditions must be obtained through the specialty pharmacy program. Manufacturer coupons may not be applied to copay for non-preferred specialty drugs. Prescribed preventive generic medications to treat
	Non-Preferred Generic drugs	$10 Copay/Prescription (retail 30-day) $20 Copay/Prescription (retail 90-day) $20 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Preferred brand drugs	$40 Copay/Prescription (retail 30-day) $80 Copay/Prescription (retail 90-day) $80 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred brand drugs	$75 Copay/Prescription (retail 30-day) $150 Copay/Prescription (retail 90-day) $150 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	

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)	
	Preferred Specialty drugs	$75 Copay/Prescription (preferred specialty medication copay cards accepted)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	one of the conditions designated Essential Health Benefit by the Affordable Care Act, such as hyperlipidemia, have a $0 copay. Certain additional requirements such as age, sex, and diagnosis may also need to be met.
	Non-Preferred Specialty drugs	$75 Copay/Prescription	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
If you have outpatient surgery (Must meet Deductible)	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance for Outpatient Hospital Facility	Deductible + 40% Coinsurance for Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
If you need immediate medical attention (No Deductible)	Emergency room care	$500 Copayment	$500 Copayment	Waived if Admitted
	Emergency medical transportation	$250 Copayment	$250 Copayment	None
	Urgent care	$30 Copayment/Visit	$30 Copayment/Visit	None
	Teladoc Telemedicine	$5 Copayment/Visit	Not Covered	None
If you have a hospital stay (Must meet Deductible)	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per benefit period.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None

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 mental health, behavioral health, or substance abuse services Inpatient: (Must Meet Deductible) Outpatient: (No Deductible) For more information on Behavioral Health and Substance Abuse call: 1-877-398-5816	Outpatient services	$15 Copayment/Visit	Deductible + 40% Coinsurance	None
	Inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Limited to 60 days per Plan Year
If you are pregnant (In-network: Full deductible not required until delivery)	Prenatal and postnatal care	$15 Copayment (Initial Visit Only)	Deductible + 40% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Rehabilitation services	$20 Copayment/Visit for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Up to 60 combined visits per benefit period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior Authorization required
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Up to 60 visits per benefit period

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 + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Hospice services	No Charge	Deductible + 40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's glasses	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's dental check-up	Covered under Dental Plan	See Dental Plan	See Dental Plan

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
- Long-Term Care
- Weight loss programs
- Cosmetic surgery
- Routine Eye Care
- Infertility treatments
- Dental care
- Routine Foot Care unless for treatment of diabetes

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

- Diagnosis of Infertility
- Bariatric Surgery with prior authorization
- Chiropractic Care
- Coverage provided outside the United States. See www.bluecardworldwide.com
- Hearing Aids
- Non-emergency care when traveling outside the United States

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-258-9029. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa. 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 questions about your rights, this notice, or assistance, you can contact any or all of the following:

• 1-855-258-9029 or visit us at www.MyHealthToolkitFL.com
• The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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 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.

Language Access Services:

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng customer service na makikita sa unang pahina ng paunawang ito.

Chinese:

如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo:

T'áá Dinéjí shił hane'go shiká i'doolwoł ninizingo éí Nidaalnishígíí Áká Anidaalwo'igíí, customer service, bich'į' hodiilnih. Bik'ehgo bich'į' hane'igíí éí díí naaltsoos neiyi'niligíí akáa'gi siltsoozígíí bikáá' íishjááh.

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

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	$3,000
Specialist copayment	$35
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	$12,991

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$35
Coinsurance	$1,370
The total Peg would pay is	$4,405

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

The **plan's** overall deductible	$3,000
Specialist copayment	$35
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	$7,690

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$675
Coinsurance	$55
The total Joe would pay is	$730

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

The **plan's** overall deductible	$3,000
Specialist copayment	$35
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	$2,187

In this example, Mia would pay:

Cost Sharing	
Deductibles	$183
Copayments	$500
Coinsurance	$155
The total Mia would pay is	$838

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