 **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](http://www.cciio.cms.gov) or call **1-800-830-1501** to request a copy.


Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$2,500</b> in-network per person; <b>\$5,000</b> family/ <b>\$4,000</b> out-of-network per person; <b>\$10,750</b> family.	You must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . The deductible starts over each April 1 <sup>st</sup> . See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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 <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	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.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$4,000</b> in-network per person; <b>\$8,000</b> family/ <b>\$7,500</b> out-of-network per person/ <b>\$15,000</b> family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://myhealthtoolkitfl.com">http://myhealthtoolkitfl.com</a> , contact Essential Advocate at 1-888-521-2583 or call BCBS customer service at 1-855-258-9029 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. See the chart starting on page 2 for how this plan pays different kinds of providers.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the specialist you choose without permission from this plan.

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.  
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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**Preferred PPO Blue Options Health Insurance Plan**

**Coverage Period: 04/01/2021 – 03/31/2022**

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic (No Deductible)</b>	Primary care visit to treat an injury or illness	20% Coinsurance/Visit	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs.  Blue Distinction Total Care Primary Care Provider (internal medicine, family medicine and pediatric medicine) Visits Are Always Free. Therapy and Chiropractic visits are limited to 60 each, per Plan Year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	0% Coinsurance/Visit	Not Applicable	
	<u>Specialist</u> visit	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	Convenient Care Clinic	\$10 Copayment/Visit	Not Applicable	
	Physical/Occupational/Speech Therapy and Chiropractor Visits	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
	<u>Diagnostic test</u> (blood work)	\$0 for Quest Diagnostic Laboratories; 20% Coinsurance for clinical outpatient facility labs	Deductible + 40% Coinsurance	
<b>If you have a test</b>	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	Deductible + 40% Coinsurance family physician,	Prior Authorization required.

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**Preferred PPO Blue Options Health Insurance Plan**

**Coverage Period: 04/01/2021 – 03/31/2022**

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 Testing Center and Outpatient Hospital facility	Independent Diagnostic Testing Center and Outpatient Hospital facility	
<p><b>If you need drugs to treat your illness or condition</b>            More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a></p> <p><b>(No Deductible)</b></p> <p>Out of pocket limit is \$2,000 in-network for individual, \$4,000 family. No limit for out-of-network.</p>	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)	<p><b>Retail 30:</b> 30 day supply;  <b>Retail 90:</b> 84-91 day supply;  <b>Mail Order:</b> 84-91 day supply</p> <p><b>Specialty Drugs:</b> 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.</p> <p>Certain drugs for hyperlipidemia are covered at 100%, with pre-authorization required.</p>
	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)	
	Preferred Specialty drugs	\$75 Copay/Prescription (preferred specialty medication copay cards accepted)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred Specialty drugs	\$75 Copay/Prescription	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**Preferred PPO Blue Options Health Insurance Plan**

**Coverage Period: 04/01/2021 – 03/31/2022**

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)	
<b>If you have outpatient surgery (Must meet Deductible)</b>	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
<b>If you need immediate medical attention (No Deductible)</b>	<u>Emergency room care</u>	\$300 Copayment	\$300 Copayment	Waived if Admitted
	<u>Emergency medical transportation</u>	\$250 Copayment	\$250 Copayment	None
	<u>Urgent care</u>	\$30 Copayment/Visit	\$30 Copayment/Visit	None
	<u>Teladoc</u>	\$5 Copayment/Visit	Not Covered	None
<b>If you have a hospital stay (Must meet Deductible)</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% Coinsurance	Deductible + 40% Coinsurance	None
	Inpatient: <b>(Must Meet Deductible)</b> Outpatient: <b>(No Deductible)</b>	Inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance
<b>For more information on Behavioral Health and Substance Abuse call: 1-877-398-5816</b>				

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**Preferred PPO Blue Options Health Insurance Plan**

**Coverage Period: 04/01/2021 – 03/31/2022**

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)	
<b>If you are pregnant</b>  (In-network: Full deductible not required until delivery)	Prenatal and postnatal care	\$20 Copayment	Deductible + 40% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	<a href="#">Rehabilitation services</a>	20% Coinsurance 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.
	<a href="#">Habilitation services</a>	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior Authorization required
	<a href="#">Skilled nursing care</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Up to 60 visits per benefit period
	<a href="#">Durable medical equipment</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	<a href="#">Hospice services</a>	No Charge	Deductible + 40% Coinsurance	None
<b>If your child needs dental or eye care</b>	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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Long-Term Care</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Routine Eye Care</li> <li>• Infertility treatments</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Routine Foot Care unless for treatment of diabetes</li> </ul>

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

- |                                              |                                                                                                                                |                                                               |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| • Diagnosis of Infertility                   | • Chiropractic Care                                                                                                            | • Hearing Aids                                                |
| • Bariatric Surgery with prior authorization | • Coverage provided outside the United States.<br>See <a href="http://www.bluecardworldwide.com">www.bluecardworldwide.com</a> | • 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](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 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](http://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](#).

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### 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。

T'áá Dinéji shil hane'go shiká i'doolwoł ninizingo éi Nidaalnishígii Áká Anidaalwo'igii, customer service, bich'í' hodiilnih. Bik'ehgo bich'í' hane'igii éi díi naaltsoos neiyi'niligii akáa'gi siltsoozigii bikáá' iishjééh.

Navajo:

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*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 [plan's](#) overall [deductible](#) \$2,500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,991</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$20
Coinsurance	\$1,370
<b>The total Peg would pay is</b>	<b>\$3,890</b>

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,690</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$675
Coinsurance	\$55
<b>The total Joe would pay is</b>	<b>\$730</b>

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,187</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$183
Copayments	\$300
Coinsurance	\$155
<b>The total Mia would pay is</b>	<b>\$638</b>