 **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>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.


You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.

OMB Control Numbers 1545-0047/Exp Date: 12/31/19, 1210-0147/Exp Date: 5/31/22, and 0938-1146/Exp Date: 10/31/22



**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.

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



**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)	

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.  
 If you aren't clear about any of the underlined terms used in this form, see the Glossary.  
 You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



**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>	<a href="#">Emergency room care</a>	\$300 Copayment	\$300 Copayment	Waived if Admitted
	<a href="#">Emergency medical transportation</a>	\$250 Copayment	\$250 Copayment	None
	<a href="#">Urgent care</a>	\$30 Copayment/Visit	\$30 Copayment/Visit	None
	<a href="#">Teladoc</a>	\$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>				

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



**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>

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



**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](#).

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



### 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:

---

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

---

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.

**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)

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

**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%

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

- 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*)

**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*)

**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>\$12,991</b>
---------------------------	-----------------

<b>Total Example Cost</b>	<b>\$7,690</b>
---------------------------	----------------

<b>Total Example Cost</b>	<b>\$2,187</b>
---------------------------	----------------

**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>

**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>

**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>



# Summary of PPO Benefits

Benefit Period April 1-March 31



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
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
<b>Deductible Per Benefit Period (PBP)</b>		
Individual	\$2,500	\$4,000
Family	\$5,000	\$10,750
<b>Coinsurance</b>	20%	40%
<b>Out-of-Pocket Maximums PBP</b> <i>(includes deductible, coinsurance, and medical copays)</i>		
Individual	\$4,000	\$7,500
Family	\$8,000	\$15,000
<b>Lifetime Maximum</b>	<b>No Maximum</b>	
<b>Physician Office Visits</b> <i>(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)</i>	20% (not subject to deductible)	40% after deductible
<b>Blue Distinction Total Care Office Visit</b> <i>(Internal Medicine, Family Practice, Pediatrician)</i>	0% (not subject to deductible or copayment)	N/A
<b>Teladoc Telemedicine Visit</b>	0% after \$5 copay	N/A
<b>Maternity Office Visit Benefit</b> <i>(initial OB visit only)</i>	\$20 copay (not subject to deductible)	40% after deductible
<b>Specialist Office Visits</b>	20% (not subject to deductible)	40% after deductible
<b>Independent Clinical Labs **</b> <i>(free standing facilities and office visits)</i>	0% (not subject to deductible)	40% after deductible
<b>Outpatient Facility (Hospital setting)***</b>	20% coinsurance	
<b>Preventive Care - Annual Physical and Gynecological exam</b>	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
<b>Related Wellness Services</b> (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)

Effective 4/1/2021

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
Allergy Injections	0% (not subject to deductible)	40% after deductible
Emergency Room Services	0% after \$300 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 is 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% (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Outpatient Speech Therapy (Restorative services only)	20% (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Outpatient Occupational Therapy	20% (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Spinal Manipulation	20% (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
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 Limit: 60 days/ benefit period	40% after deductible
Skilled Nursing Rehabilitation	20% after deductible Limit: 60 days/ benefit period	40% after deductible
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	20% (not subject to deductible)	40% after deductible

Note on Out-of-Network Providers: Services rendered by an out-of-network provider may be subject to balance billing by the out-of-network provider for the difference between the allowed amount and provider billed charges. 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.