

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

\$4,000/\$8,000 Deductible PPO Plan

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
Deductible Per Benefit Period (PBP)		
Individual	\$4,000	\$8,000
Family	\$8,000	\$16,000
Coinsurance	30%	50%
Out-of-Pocket Maximums PBP <i>(includes deductible, coinsurance, and medical copays)</i>		
Individual	\$5,350	\$10,700
Family	\$10,700	\$21,400
Lifetime Maximum	No Maximum	
Physician Office Visits <i>(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)</i>	0% after \$35 copay (not subject to deductible)	50% after deductible
Blue Distinction Total Care Office Visit <i>(Internal Medicine, Family Practice, Pediatrician)</i>	\$0 copay (not subject to deductible or copayment)	N/A
Teladoc Telemedicine Visit	0% after \$5 copay	N/A
Maternity Office Visit Benefit <i>(initial OB visit only)</i>	0% after \$35 copay (not subject to deductible)	50% after deductible
Specialist Office Visits	0% after \$70 copay (not subject to deductible)	50% after deductible
Independent Clinical Labs * <i>(free standing facilities and office visits)</i>	0% (not subject to deductible)	50% after deductible
Outpatient Facility (Hospital setting) **	30% coinsurance	
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)

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Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
Allergy Injections	0% (not subject to deductible)	50% 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 \$70 copay	
Hospital Expenses		
Inpatient	30% after deductible	50% after deductible
Outpatient	30% after deductible	50% after deductible
Outpatient Surgery Office Setting		
Physician	0% after \$35 Copay	50% after deductible
Specialist	0% after \$70 Copay	
Outpatient Facility	30% after deductible	50% after deductible
Related professional services	30% after deductible	50% after deductible
<i>Non-Emergent Surgeries with SurgeryPlus</i> <i>Please call 1-855-200-2119 for this separate benefit</i>	<i>Deductible and coinsurance is waived when utilizing SurgeryPlus services and network</i>	<i>Not Covered</i>
Infertility Services (Counseling and testing to diagnose only)	30% after deductible	50% after deductible
Outpatient Physical Therapy ***	0% after \$40 copay (not subject to deductible) Limit: 30 visits/ benefit period	50% after deductible
Outpatient Speech Therapy *** (Restorative services only)	0% after \$40 copay (not subject to deductible) Limit: 30 visits/ benefit period	50% after deductible
Outpatient Occupational Therapy	0% after \$40 copay (not subject to deductible) Limit: 30 visits/ benefit period	50% after deductible
Spinal Manipulation	0% after \$40 copay (not subject to deductible) Limit: 60 visits/ benefit period	50% after deductible
Diagnostic Services (X-Ray and other tests)	30% after deductible	50% after deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	Allowed Charges up to \$500 Copay	50% after deductible
Durable Medical Equipment (DME)	\$2,000 Deductible of the \$4,000 Individual Deductible must be satisfied before 30% coinsurance applies	50% after deductible
Prosthetic Appliances		50% after deductible
Hearing aid screening/exam	30% (not subject to deductible)	
Hearing aid	30% after in-network DME deductible Combined limit: \$1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	30% after deductible	50% after deductible
Inpatient Rehabilitation	30% after deductible Limit: 60 days/ benefit period	50% after deductible
Skilled Nursing Rehabilitation	30% after deductible Limit: 60 days/ benefit period	50% after deductible
Home Health Care	30% after deductible	50% after deductible
Private Duty Nursing	30% after deductible	50% after deductible
Hospice (Inpatient and Outpatient Care)	0% (not subject to deductible)	50% 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	30% after deductible	50% after deductible
Outpatient	0% after \$35 copay	50% after deductible

***Up to 60 visits/benefit period combined with occupational therapy.

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.

ICUBA April 1, 2019 – March 31, 2020
 Prescription Medication Plan

The following is a brief overview of your pharmacy benefit[‡]. To help keep your costs low, ICUBA pays a portion of the cost, and you pay the rest.

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. Call toll-free at (800) 763-0044.

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 through local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling. (See flyer for more information!)

Specialty Medications

Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Briova Specialty Pharmacy. Call Briova toll-free at (855) 4BRIOVA.

Optum Rx Web Portal

Find answers by visiting the OptumRx Portal through the single sign-on section at ICUBAbenefits.org with features designed so you can find your lowest copay, manage your Home Delivery prescriptions, keep track of your health history and more!

Health Care Advisor

If you have a question about your pharmacy benefit, call the Health Care Advisor team toll-free at (855) 811-2213, 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*		
	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
Tier			
Preferred generics at the Nova Southeastern University (NSU) pharmacy	\$0	\$0	N/A
Preferred generics at other network pharmacies	\$5	\$10	\$10
Non-Preferred generics	\$10	\$20	\$20
Preferred brands: brand-name medications on the Preferred Medication List (PML)**	\$40	\$80	\$80
Non-preferred brands: brand-name medications not on the Preferred Medication List	\$75	\$150	\$150
Preferred specialty at Briova Specialty Pharmacy	\$75***	N/A	N/A
Non-preferred specialty at Briova 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 PML is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs. You can view the PML online by visiting optumrx.com

*** Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products

\$4,000/\$8,000 Deductible PPO Plan

Aetna Behavioral Health and Substance Abuse

Aetna Open Choice PPO Network


EAP, Mental Health, Substance Abuse Benefits and Applied Behavioral Analysis (ABA) are provided by Aetna Behavioral Health Available 24 hours at 877-398-5816		
Deductibles and Out of Pocket Maximum Amounts are COMBINED with BCBS Medical		
	In Network	Out of Network
Employee Assistance Program (EAP) <i>Up to 6 short-term professional counseling sessions per episode per year. Talk with a licensed clinician regarding stress, relationship issues, grief, etc.</i>	\$0	No coverage
Inpatient*	30% after deductible	50% after deductible
Mental Health Hospital Admission*	30% after deductible	50% after deductible
Substance Abuse Hospital Admission*	30% after deductible	50% after deductible
Residential* <i>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.</i>	30% after deductible	50% after deductible
Inpatient Detoxification* <i>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.</i>	30% after deductible	50% after deductible
Outpatient	\$35 copayment (not subject to deductible)	50% after deductible
Professional Counseling Sessions <i>Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.</i>	\$35 copayment (not subject to deductible)	50% after deductible
Psychiatric Medication Evaluation	\$35 copayment (not subject to deductible)	50% after deductible
Applied Behavioral Analysis Therapy* <i>Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis</i>	\$35 copayment (not subject to deductible)	50% after deductible
Partial Hospitalization (PHP)* <i>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.</i>	\$35 copayment (not subject to deductible)	50% after deductible
Outpatient Detoxification* <i>Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.</i>	\$35 copayment (not subject to deductible)	50% after deductible
Intensive Outpatient Sessions (IOP)* <i>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.</i>	\$35 copayment (not subject to deductible)	50% after deductible
AbleTo <i>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.</i>	\$0	No coverage

*Services require prior-authorization

SurgeryPlus is a supplemental benefit at NO ADDITIONAL COST that offers higher-quality, a great experience and lower costs for non-emergent surgical procedures.

SurgeryPlus has Located the Nation’s Top-Quality Surgeons

SurgeryPlus has already located and rigorously screened the area’s top-quality surgeons for the best possible care. Our highly qualified surgeons chose to be part of the SurgeryPlus network for a number of reasons, including quick and easy claims payments, no denials, direct referrals of surgery-ready patients and the opportunity to participate in an elite network setting them apart from other under-performing surgeons.

	Other Network	
Board Certification	Optional	Mandatory
Specialty Training Requirements	Optional	Mandatory
Procedure Volume Requirements	<input type="checkbox"/>	<input checked="" type="checkbox"/>
State Sanctions Check	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medical Malpractice Claims Review	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Criminal Background Checks	<input type="checkbox"/>	<input checked="" type="checkbox"/>
CMS Quality Requirements (Hospital Only)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Monthly Network Monitoring	<input type="checkbox"/>	<input checked="" type="checkbox"/>

You Can Save Money

SurgeryPlus will waive your coinsurance and deductible, eliminating all out-of-pocket costs, including consultation, surgical procedure and post-procedure appointments up to 90 days.

Care Advocates Manage the Entire Process

A dedicated Care Advocate will manage the entire procedure process for you, including locating a surgeon, scheduling appointments, transferring medical records and arranging all logistics. You’ll work with the same Care Advocate throughout the entire process so they’ll know all the details of your case and ensure your top-satisfaction. The Care Advocate will provide you with at least three top quality surgeons for your covered procedure. In the event that the surgeon you select requires you to travel, SurgeryPlus will provide you and a companion with a travel allowance.

Hundreds of Procedures are Covered

Hundreds of procedures are covered. Below is a list of the main categories; however, call SurgeryPlus to inquire about a specific procedure and a Care Advocate will assist you with your needs and questions.

- Spine
- Cardiac
- General Surgery
- Genitourinary
- Orthopedic
- Ear, Nose & Throat
- Pain Management
- Bariatric

You Do Not Need to Enroll in SurgeryPlus

If you are covered under ICUBA’s medical plan, you have been automatically enrolled in this extra benefit at no additional cost. If you are planning a procedure, call SurgeryPlus as you could save thousands of dollars.

To learn more about SurgeryPlus, call (855) 200-2119




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://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,000 in-network per person; \$8,000 family/ \$8,000 out-of-network per person; \$16,000 family.	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services you use. 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 1 st . 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?	\$5,350 in-network per person; \$10,700 family/ \$10,700 out-of-network per person/ \$21,400 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.

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 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 <u>provider's</u> office or clinic (No Deductible)	Primary care visit to treat an injury or illness	\$35 Copayment/Visit	Deductible + 50% Coinsurance	Additional cost shares may apply for physician administered drugs.
	<u>Specialist</u> visit	\$70 Copayment/Visit	Deductible + 50% Coinsurance	
	Convenient Care Clinic	\$10 Copayment/Visit	\$10 Copayment/Visit	Blue Distinction Total Care Primary Care Provider (internal medicine, family medicine and pediatric medicine) Visits Are Always Free.
	Physical/Occupational/Speech Therapy and Chiropractor Visits	\$40 Copayment/Visit	Deductible + 50% Coinsurance	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
	<u>Diagnostic test</u> (blood work)	\$0 for Quest Diagnostic Laboratories; 30% Coinsurance for clinical outpatient facility labs	Deductible + 50% Coinsurance	Therapy visits are limited to 30 per Plan Year. Physical or Speech may be combined with Occupational for 60 visits per year. Chiropractic Visits limited to 60 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.	

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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)	
If you have a test	X-Ray	Deductible + 30% Coinsurance	Deductible + 50% 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 + 50% 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.optumrx.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. Certain drugs for hyperlipidemia are covered at 100%, with pre-authorization required.
	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	

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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)	
			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 + 30% Coinsurance for Outpatient Hospital Facility	Deductible + 50% Coinsurance for Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 50% 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	\$70 Copayment/Visit	\$70 Copayment/Visit	None
	Teladoc	\$5 Copayment/Visit	Not Covered	None
If you have a hospital stay (Must meet Deductible)	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per benefit period.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 Copayment/Visit	Deductible + 50% Coinsurance	None
	Inpatient: (Must Meet Deductible) Outpatient: (No Deductible)	Inpatient services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance Prior Authorization required. Limited to 60 days per Plan Year
For more information on Behavior Health				

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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)	
and Substance Abuse call: 1-877-398-5816				
If you are pregnant (In-network: Full deductible not required until delivery)	Prenatal and postnatal care	\$35 Copayment	Deductible + 50% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Prior Authorization required
	Rehabilitation services	\$40 Copayment for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 50% 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 + 30% Coinsurance	Deductible + 50% Coinsurance	Up to 60 visits per benefit period
	Durable medical equipment	Deductible + 30% Coinsurance; Deductible is limited to \$2,000 and counts towards the plan's overall deductible	Deductible + 50% Coinsurance	Prior Authorization required
	Hospice services	No Charge	Deductible + 50% 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

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

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. See www.bluecardworldwide.com | • 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 www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 www.dol.gov/ebsa/healthreform

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.

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.

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.



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 Dinéji shil hane'go shiká i' doolwol ninizingo éi Nidaalnishigii Áká Anidaalwo'igii, customer service, bich'j' hodiilnih. Bik'ehgo bich'j' hane'igii éi dii naaltsoos neiyi'niligii akáa'gi siltsoozigii bikáá' iishjááh.


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](#) \$4,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*)

Total Example Cost	\$12,991
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Total Example Cost	\$7,690
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Total Example Cost	\$2,187
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$35
Coinsurance	\$1,315
The total Peg would pay is	\$5,350

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$815
Coinsurance	\$0
The total Joe would pay is	\$815

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$183
Copayments	\$780
Coinsurance	\$0
The total Mia would pay is	\$963