### Important Questions

<table>
<thead>
<tr>
<th></th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$2,500 in-network per person; $5,000 family/$4,000 out-of-network per person; $10,750 family.</td>
<td>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 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>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.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$4,000 in-network per person; $8,000 family/$7,500 out-of-network per person/$15,000 family. There is a separate out-of-pocket limit for prescription drugs (see page 3).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>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 network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage

**Premier Copay PPO Blue Options Health Insurance Plan**

**Coverage Period:** 04/01/2020 – 03/31/2021

---

### All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic (No Deductible)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 Copayment/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td>Additional cost shares may apply for physician administered drugs.</td>
</tr>
<tr>
<td>Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)</td>
<td>$0 Copayment/Visit</td>
<td>Not Applicable</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Specialist</strong> visit</td>
<td>$50 Copayment/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Convenient Care Clinic</td>
<td>$10 Copayment/Visit</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Physical/Occupational/Speech Therapy and Chiropractor Visits</td>
<td>$30 Copayment/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic test</strong> (blood work)</td>
<td>$0 for Quest Diagnostic Laboratories; 20% Coinsurance for clinical outpatient facility labs</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$500 Copay (or actual cost if less) for family physician, Independent</td>
<td>Deductible + 40% Coinsurance family physician,</td>
<td>Prior Authorization required.</td>
</tr>
</tbody>
</table>

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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

**Premier Copay PPO Blue Options Health Insurance Plan**

**Coverage Period:** 04/01/2020 – 03/31/2021

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostic Testing Center and Outpatient Hospital facility</td>
<td>Independent Diagnostic Testing Center and Outpatient Hospital facility</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic drugs</td>
<td>$0 Copay/Prescription (retail 30 and 90-day at NSU pharmacy, NCPDP# 1082041)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Generic drugs</td>
<td>$10 Copay/Prescription (retail 90-day)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$40 Copay/Prescription (mail order)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred brand drugs</td>
<td>$75 Copay/Prescription (mail order)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Preferred Specialty drugs</td>
<td>$75 Copay/Prescription (preferred specialty medication copay cards accepted)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Specialty drugs</td>
<td>$75 Copay/Prescription</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

- **More information about prescription drug coverage** is available at [www.optumrx.com](http://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.

- **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.

### If you have outpatient surgery (Must meet Deductible)

- Facility fee (e.g., ambulatory surgery center)

**Limitations, Exceptions, & Other Important Information**

- **None**

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# Summary of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

**Premier Copay PPO Blue Options Health Insurance Plan**

**Coverage Period:** 04/01/2020 – 03/31/2021

## Common Medical Event

### Services You May Need

<table>
<thead>
<tr>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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<tbody>
<tr>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
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</table>

### If you need immediate medical attention (No Deductible)

- **Physician/surgeon fees**
  - Deductible + 20% Coinsurance
  - Deductible + 40% Coinsurance
  - None

- **Emergency room care**
  - $300 Copayment
  - $300 Copayment
  - Waived if Admitted

- **Emergency medical transportation**
  - $250 Copayment
  - $250 Copayment
  - None

- **Urgent care**
  - $50 Copayment/Visit
  - $50 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 + 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

### If you need mental health, behavioral health, or substance abuse services

- **Outpatient services**
  - $25 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**
  - $25 Copayment
  - Deductible + 40% Coinsurance
  - None

- **Childbirth/delivery and all facility services**
  - Deductible + 20% Coinsurance
  - Deductible + 40% Coinsurance
  - None

---

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<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$30 Copayment for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility</td>
<td>Deductible + 40% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered, except for Autism Benefits</td>
<td>Not Covered, except for Autism Benefits</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>Deductible + 40% Coinsurance</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Services</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>Covered under Vision Plan</td>
<td>See Vision Plan</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Covered under Vision Plan</td>
<td>See Vision Plan</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Covered under Dental Plan</td>
<td>See Dental Plan</td>
</tr>
</tbody>
</table>

## 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

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

Navajo:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**Summary of Benefits and Coverage**: What this Plan Covers & What You Pay For Covered Services

**Premier Copay Blue Options Health Insurance Plan**

**Coverage Period**: 04/01/2020 – 03/31/2021

---

**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 copayment** $50
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
<td>$25</td>
<td>$1,370</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$3,895</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 copayment** $50
- **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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
<td>$775</td>
<td>$0</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$775</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- The **plan's overall deductible** $2,500
- **Specialist copayment** $50
- **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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$183</td>
<td>$520</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$703</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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