Preferred PPO Blue Options Health Insurance Plan

Coverage Period: 04/01/2015 – 03/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and/or Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://icubabenefits.org or by calling 1-866-377-5102. In the event there is a conflict between this summary and your ICUBA coverage documents the terms and conditions of the coverage documents will control.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** in-network per person; **$4,000** family/**$3,500** out-of-network per person; **$9,750** family. Doesn't apply to in-network: preventive care, office visits, or prescription drugs. Doesn't apply to in- or out-of-network: emergency room, urgent care, or emergency transportation.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over each April 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes**. **$3,500** in-network per person; **$7,000** family/**$7,000** out-of-network per person; **$14,000** family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges for out-of- network services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **participating providers**, see www.floridablue.com or call 1-800-664-5295.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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 **www.floridablue.com** or call 1-800-664-5295 to request a copy.

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Released on April 23, 2013 (corrected)

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic (No Deductible)	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 Physician Recognition Primary Care Provider Visits Are Always Free.** Quest Diagnostic is the exclusive provider of in-network laboratory services.
	Specialist visit	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	Other practitioner office visit	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	Preventive care/ screening/immunization	No Charge	Not Covered	
	Blood Work	$0 for Quest Diagnostic Laboratories	Deductible + 40% Coinsurance for Independent Clinical Lab.	
If you have a test (Must meet Deductible)	X-Ray	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.catamaranrx.com **(No Deductible)** Out of pocket limit is $2,000 in-network for individual, $4,000 family. No limit for out-of-network.	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.
	Preferred brand drugs	$27 Copay/Prescription (retail 30-day) $50 Copay/Prescription (retail 90-day) $50 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-preferred brand drugs	$60 Copay/Prescription (retail 30-day) $120 Copay/Prescription (retail 90-day) $120 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Specialty drugs	Refer to the applicable formulary category (generic, preferred, non-preferred) for cost	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
If you have outpatient surgery (Must meet Deductible)	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance for Outpatient Hospital Facility	Deductible + 40% Coinsurance for Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
If you need immediate medical attention (No Deductible)	Emergency room services	$100 Copayment	$100 Copayment	None
	Emergency medical transportation	$250 Copayment	$250 Copayment	None
	Urgent care	20% Coinsurance	20% Coinsurance	None
If you have a hospital stay (Must meet Deductible)	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Inpatient Rehabilitation Services are limited to 60 days per benefit period. Prior authorization required.
	Physician/surgeon fee	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs **Inpatient: (Must Meet Deductible)** **Outpatient: (No Deductible)**	Mental/Behavioral health outpatient services	20% Coinsurance	Deductible + 40% Coinsurance	None
	Mental/Behavioral health inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior authorization required.
	Substance use disorder outpatient services	20% Coinsurance	Deductible + 40% Coinsurance	None
	Substance use disorder inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior authorization required.
If you are pregnant (In-network: Full deductible not required until delivery)	Prenatal and postnatal care	$20 Copayment	Deductible + 40% Coinsurance	None
	Delivery and all inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs **(Must meet Deductible for all except for Rehabilitation services)**	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior authorization required.
	Rehabilitation services	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 for physical, speech and occupational therapies per benefit period.
	Habilitation services	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior authorization required.
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage is limited to 60 days per benefit period.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior authorization required.
	Hospice service	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
If your child needs dental or eye care	Eye exam	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Glasses	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Dental check-up	Covered under Dental Plan	See Dental Plan	See Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery with prior authorization
- Diagnosis of Infertility
- Private-duty nursing
- Chiropractic care
- Coverage provided outside the United States. See www.bluecardworldwide.com.
- Hearing aids
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-377-5102. You may also contact your state insurance department at **1-877-693-5236**, 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.

Your Grievance and Appeals Rights:

For more information on your rights to a **grievance** or **appeal**, contact the insurer at 1-800-664-5295. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, state insurance department at 1-877-693-5236.

For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-664-5295.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-664-5295.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-664-5295.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-664-5295.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,520
- **Patient pays** $3,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$60
Coinsurance	$960
Limits or exclusions	None
Total	**$3,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,450
- **Patient pays** $950

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$510
Coinsurance	$140
Limits or exclusions	None
Total	**$950**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSA's), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.