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 deductable amount before this plan begins to pay for covered services you use. The deductable starts over each April 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductable. |
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. |
• **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic (No Deductible)</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% Coinsurance/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td>Additional cost shares may apply for physician administered drugs.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coinsurance/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% Coinsurance/Visit</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood Work</td>
<td>$0 for Quest Diagnostic Laboratories</td>
<td>Deductible + 40% Coinsurance for Independent Clinical Lab.</td>
<td></td>
</tr>
<tr>
<td>If you have a test (Must meet Deductible)</td>
<td>X-Ray</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Deductible + 20% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility</td>
<td>Deductible + 40% Coinsurance for Family Physician, Independent Diagnostic Testing Center and Outpatient Hospital Facility</td>
<td>Prior authorization required.</td>
</tr>
</tbody>
</table>

Questions: Call 1-866-377-5102 or visit us at http://icubabenefits.org.
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### Preferred PPO Blue Options Health Insurance Plan

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

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

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>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>Retail 30: 30 day supply; Retail 90: 84-91 day supply; Mail Order: 84 – 91 day supply</td>
</tr>
<tr>
<td>(No Deductible)</td>
<td>Preferred brand drugs</td>
<td>$27 Copay/Prescription (retail 30-day)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td>Specialty Drugs: Certain medications used for treating complex health conditions must be obtained through the specialty pharmacy program.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 Copay/Prescription (retail 30-day)</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Refer to the applicable formulary category (generic, preferred, non-preferred) for cost</td>
<td>40% Coinsurance (after payment in full and filing paper claim for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery (Must meet Deductible)</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Deductible + 20% Coinsurance for Outpatient Hospital Facility</td>
<td>Deductible + 40% Coinsurance for Outpatient Hospital Facility</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention (No Deductible)</td>
<td>Emergency room services</td>
<td>$100 Copayment</td>
<td>$100 Copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$250 Copayment</td>
<td>$250 Copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay (Must meet Deductible)</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>Inpatient Rehabilitation Services are limited to 60 days per benefit period. Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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### Preferred PPO Blue Options Health Insurance Plan

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

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

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>$20 Copayment</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>(In-network: Full deductible not required until delivery)</strong></td>
<td>Delivery and all inpatient services</td>
<td>Deductible + 20% Coinsurance</td>
<td>Deductible + 40% Coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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**Preferred PPO Blue Options Health Insurance Plan**

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

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

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

**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**<br>(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

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**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](http://www.bluecardworldwide.com).
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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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

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 a't'ohwol ninisingo, kwiijigo holne' 1-800-664-5295.

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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:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

#### 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:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

#### Patient pays:

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

---

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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.

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