Summary of EPO Benefits

Benefit Period August 1, 2026 -March 31, 2027

This is an EPO Plan, or Exclusive Provider Organization. Members have limited out-of-area benefits. Members will continue to have access to the same BlueCross BlueShield provider network available today. 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 High Deductible EPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Healthcare Coverage Summary		
Deductible Per Benefit Period (PBP)		
Individual Family	$4,500 $9,000	Not Covered
Coinsurance	30%	Not Covered
Out-of-Pocket Maximums PBP		
Individual Family	$8,600 $17,200	Not Covered
Lifetime Maximum	No Maximum	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	$15 copay (not subject to deductible)	Not Covered
Total Care Physician Office Visit *(Internist, Family Practice, Pediatrician)*	0% (not subject to deductible)	Not Applicable
Embold Physician Office Visit	0% (not subject to deductible)	Not Applicable
Teladoc Telemedicine Visit	0% after $5 copay	Not Applicable
Maternity Office Visit Benefit *(initial OB visit only)*	$15 copay (not subject to deductible)	Not Covered
Specialist Office Visits	$35 copay (not subject to deductible)	Not Covered
Independent Clinical Labs (medically necessary)[1]		
Quest Diagnostics and office visits Outpatient Facility (Hospital setting) [2]	0% (not subject to deductible) 30% coinsurance	Not Covered
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
Allergy Injections	0% (not subject to deductible)	Not Covered
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	Not Covered
Urgent Care Center	0% after $30 copay	Not Covered
Hospital Expenses Inpatient	30% after deductible	Not Covered
Outpatient [3] *Services require pre-authorization*	30% after deductible	Not Covered
Outpatient Surgery Office Setting *(Physician or Specialist)*	30% (not subject to deductible)	Not Covered
Outpatient Facility	30% after deductible	Not Covered
Related professional services	30% after deductible	Not Covered
Non-Emergent Surgeries with **Lantern** **Please call 855-200-2119 for this separate benefit**	Deductible/Coinsurance waived when utilizing Lantern services and network	Not Covered

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Infertility Services *(Counseling and testing to diagnose only)*	30% after deductible	Not Covered
Outpatient Physical Therapy	$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	Not Covered
Outpatient Speech Therapy *(Restorative services only)*	$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	Not Covered
Outpatient Occupational Therapy	$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	Not Covered
Spinal Manipulation	$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	Not Covered
Diagnostic Services (X-Ray and other tests)	30% after deductible	Not Covered
Outpatient Diagnostic Imaging [3] *(MRI, MRA, CAT Scan, PET Scan)* *Services require pre-authorization*	Allowed Charges up to $500 Copay	Not Covered
Durable Medical Equipment	30% after deductible	Not Covered
Prosthetic Appliances	30% after deductible	Not Covered
Hearing Care Services		
Hearing aid screening/exam	30% (not subject to deductible)	Not Covered
Hearing aid	30% after in-network deductible Combined limit: $1,500/ benefit period	Not Covered
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	30% after deductible	Not Covered
Inpatient Rehabilitation [3] *Services require pre-authorization*	30% after deductible Limit: 60 days/ benefit period	Not Covered
Skilled Nursing Rehabilitation	30% after deductible Limit: 60 days/ benefit period	Not Covered
Home Health Care [3] *Services require pre-authorization*	30% after deductible	Not Covered
Private Duty Nursing	30% after deductible	Not Covered
Hospice: Inpatient and Outpatient [3] *Services require pre-authorization*	0% (not subject to deductible)	Not Covered
Mental Health and Substance Abuse Coverage Summary		
Mental Health or Substance Abuse Inpatient	30% after deductible	Not Covered
Outpatient	$15 copay (not subject to deductible)	Not Covered
Inpatient [3] *Services require pre-authorization*	30% after deductible	Not Covered
Mental Health Hospital Admission [3] *Services require pre-authorization*	30% after deductible	Not Covered
Substance Abuse Hospital Admission [3] Services require pre-authorization	30% after deductible	Not Covered
Residential [3] 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. *Services require pre-authorization*	30% after deductible	Not Covered
Inpatient Detoxification [3] 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 withdrawalsymptoms require 24 hour medical and nursing services. *Services require pre-authorization*	30% after deductible	Not Covered
Outpatient	$15 copay (not subject to deductible)	Not Covered
Professional Counselling Sessions Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.	$15 copay (not subject to deductible)	Not Covered
Psychiatric Medication Evaluation	$15 copay (not subject to deductible)	Not Covered

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Applied Behavioral Analysis Therapy [3] Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis. *Services require pre-authorization*	$15 copay (not subject to deductible)	Not Covered
Partial Hospitalization (PHP) [3] 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. *Services require pre-authorization*	$15 copay (not subject to deductible)	Not Covered
Outpatient Detoxification Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.	$15 copay (not subject to deductible)	Not Covered
Intensive Outpatient Sessions (IOP) 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.	$15 copay (not subject to deductible)	Not Covered
Pharmacy Benefit Coverage Summary [4]		
Prescription Pharmacy Drug Tier	**Retail: Up to 30 day supply**	**Retail or Mail: Up to 90 day supply**
Low Cost Generics at the NSU Pharmacy	$0 copayment	$0 copayment
Low Cost Generics at all other network pharmacies	$5 copayment	$10 copayment
Preventive Generics [5]	$0 copayment	
Generics: [6] *Tier 1 Medications on the Premium Formulary*	$10 copayment	$20 copayment
Preferred Brand: [6] *Tier 2 Medications on the Premium Formulary*	$55 copayment	$110 copayment
Non-Preferred Brand: [6] *Tier 3 Medications on the Premium Formulary*	$95 copayment	$190 copayment
Preferred Specialty Medication [7] *Required to use Optum Specialty Pharmacy*	20% coinsurance not to exceed $500 per covered prescription	
Non-Preferred Specialty Medication [7] *Required to use Optum Specialty Pharmacy*	20% coinsurance not to exceed $500 per covered prescription	

This summary does not constitute a contract for benefits, the information displayed here is only a summary of the benefits and programs available. Please review the Plan Document provided by your employer for a comprehensive list of covered services. 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.

1. Quest Diagnostic Labs is the In-Network Lab for BlueCross BlueShield of Florida.

2. Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center)

3. Services require prior-authorization

4. 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.

5. Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

6. The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

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

Customer Care

Provider	Number	Website
Florida Blue Care Connected	(855) 258-9029	https://member.myhealthtoolkitfl.com/
Florida Blue Nurse Case Manager	(855) 263-0675 ext. 40471	https://member.myhealthtoolkitfl.com/
Florida Blue Behavioral Health Case Manager	(800) 868-1032	https://member.myhealthtoolkitfl.com/
Quest Diagnostics	(866) 697-8378	https://Questdiagnostics.com
Optum Specialty Pharmacy	(855) 258-9029	https://member.myhealthtoolkitfl.com/
ICUBAcares Pharmacist Advocate	(877) 286-3967	www.icubacares.org
Lantern	(855) 200-2119	
Hinge Health	(855) 902-2777	www.hingehealth.com/icuba/bcbs

Florida Blue **ICUBA : High Deductible EPO**

This 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 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, call **1-855-258-9029.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary** or **www.cciio.cms.gov** or call **1-855-258-9029** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$4,500** person/**$9,000** family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	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 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network **$8,600** person/**$17,200** family.	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 **www.MyHealthToolkitFL.com** or call **1-800-810-BLUE (2583)** for a list of network providers.	Except for emergency services and any other services required by applicable law, services received from out-of-network providers are not covered. Members are responsible for the full cost of non-covered services and may also be balance billed. Certain ancillary providers (such as laboratories, anesthesiologists, radiologists, or pathologists) may participate outside your provider's network. Services covered under the No Surprises Act will be processed in accordance with applicable law.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration Date: 5/31/2022)(HHS - OMB control number: 0938-1146/Expiration Date: 10/31/2022)

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/ visit; deductible does not apply	Not Covered	Teladoc visits are covered with a $5 Copay. In-Network allergy injections/testing and labs are covered at No Charge. Convenient care clinics are covered with a $10 Copay.
	Specialist visit	$35 Copay/ visit; deductible does not apply	Not Covered	In-Network allergy injections/testing and labs are covered at No Charge.
	Preventive care/screening/ immunization	No Charge	Not Covered	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	Not Covered	In-Network independent labs are covered at No Charge.
	Imaging (CT/PET scans, MRIs)	$500 Copay/ test; deductible does not apply	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MyHealthToolkitFL.com	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)	Not Covered	**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.
	Non-Preferred Generic drugs	$10 Copay/Prescription (retail 30-day) $20 Copay/Prescription (retail 90-day) $20 Copay/Prescription (mail order)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Out of pocket limit is $2,000 in-network for individual, $4,000 family.	Preferred brand drugs	$55 Copay/Prescription (retail 30-day) $110 Copay/Prescription (retail 90-day) $110 Copay/Prescription (mail order)	Not Covered	Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act, such as hyperlipidemia, have a $0 copay. Certain additional requirements such as age, sex, and diagnosis may also need to be met
	Non-Preferred brand drugs	$95 Copay/Prescription (retail 30-day) $190 Copay/Prescription (retail 90-day) $190 Copay/Prescription (mail order)	Not Covered	
	Preferred Specialty drugs	20% Coinsurance not to exceed $500 per prescription	Not Covered	
	Non-Preferred Specialty drugs	20% Coinsurance not to exceed $500 per prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not Covered	Pre-authorization is required for some outpatient surgeries.
	Physician/surgeon fees	30% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	$500 Copay/ visit; deductible does not apply	$500 Copay/ visit; deductible does not apply	Copayment will be waived if admitted.
	Emergency medical transportation	$250 Copay; deductible does not apply	$250 Copay; deductible does not apply	None
	Urgent care	$30 Copay/ visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Not Covered	Pre-authorization is required.
	Physician/surgeon fees	30% Coinsurance	Not Covered	None

If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	$15 Copay/ visit; deductible does not apply	Not Covered	Teladoc behavioral health visits are covered with a $5 Copay.
	Substance use disorder outpatient services	$15 Copay/ visit; deductible does not apply	Not Covered	
	Mental/behavioral health inpatient services	30% Coinsurance	Not Covered	Pre-authorization is required.
	Substance use disorder inpatient services	30% Coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$15 Copay/ visit; deductible does not apply	Not Covered	Pre-authorization for facility services is required. Copay applies to the initial visit only. All subsequent office maternity services are covered at No Charge. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% Coinsurance	Not Covered	
	Childbirth/delivery facility services	30% Coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	$20 Copay/ visit; deductible does not apply	Not Covered	60 visits/benefit year each for Occupational Therapy, Physical Therapy and Speech Therapy. 60 days/benefit year for Inpatient Rehabilitation.
	Habilitation services	$20 Copay/ visit; deductible does not apply	Not Covered	60 visits/benefit year each for Occupational Therapy, Physical Therapy and Speech Therapy. 60 days/benefit year for Inpatient Rehabilitation.
	Skilled nursing care	30% Coinsurance	Not Covered	60 days/benefit year. Pre-authorization is required.
	Durable medical equipment	30% Coinsurance	Not Covered	All hearing services are limited to $1,500/benefit year.
	Hospice services	No Charge	Not Covered	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges for In-Network outpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See your Employer for benefit details
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details
	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

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	• Dental Care (Child)	• Routine Eye Care (Child)
• Cosmetic Surgery	• Long-Term Care	• Routine Foot Care
• Dental Care (Adult)	• Routine Eye Care (Adult)	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery, covered at Blue Distinction Centers only	• Hearing Aids	• Non-emergency care when traveling outside the U.S.
• Chiropractic Care, 60 visits/benefit year	• Infertility Treatment, diagnosis and testing only	• Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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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** **$4,500**
- **Specialist Copayment** **$35**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,970**

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

- **The plan's overall deductible** **$4,500**
- **Specialist Copayment** **$35**
- **Hospital (facility) Coinsurance** **30%**
- **Other Coinsurance** **30%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,660**

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

- **The plan's overall deductible** **$4,500**
- **Specialist Copayment** **$35**
- **Hospital (facility) Coinsurance** **30%**
- **Other Coinsurance** **30%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:**1-855-258-9029.**

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697(TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsenan plan sante sa a, se dwa w pou resevwa asistans ak enfomasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avek yon entepret, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous etes en train d' aider, a des quest ions apropos de ce plan medical, vous avez le droit d'obtenir de l'aide et !'information dans votre langue a aucun coOt. Pour parler a un interprete, appelez 1-844-396-0190 . (French)

Jeslr Ty lub osoba, kt6rej pomagasz, macie pytania odnosnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpfatnej informacji i pomocy we wfasnym j zyku. Aby porozmawiac z ttumaczem, zadzwon pod numer 1-844-3%-0186. (Polish)

Se voce, ou alguem a quern voce esta ajudando, tern perguntas sobre este piano de saude, voce tern o direito de obter ajuda e informa ao em seu idioma e sem custos. Para falar com um interprete, liguepara 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai ii diritto di ottenere aiuto e informazion i nella tua lingua gratuitam ente. Per parlare con un interprete, puoi chiamare 1-844-396-0184.(Italian)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

u *'.:l.b* I J .S.....S -t...S ..L...,!.) I .:i I .J 0--:!I .j. > , 0 L/ -4...L.t I .i I J...µ, IS..._. LJ.>-! 0--:!I IS o .J L/ .J .:i ._,...J'j I j....u, IJ"" .S.....S J I ,LS IS .:i_;...J L/ 1...o..:, _;JI , ..l...!;---:! 1....o. _j j...o I> *U"LA...3* **1-844-398-6233** .S o.) t.....:, L../ LJ.h..J , _)-.:i....o L/ U.:i_J-.S .S I .>-! , u.J L/.J .:I U I .) .) _,-b I .) .:I y UL/ j (Persian-Farsi)

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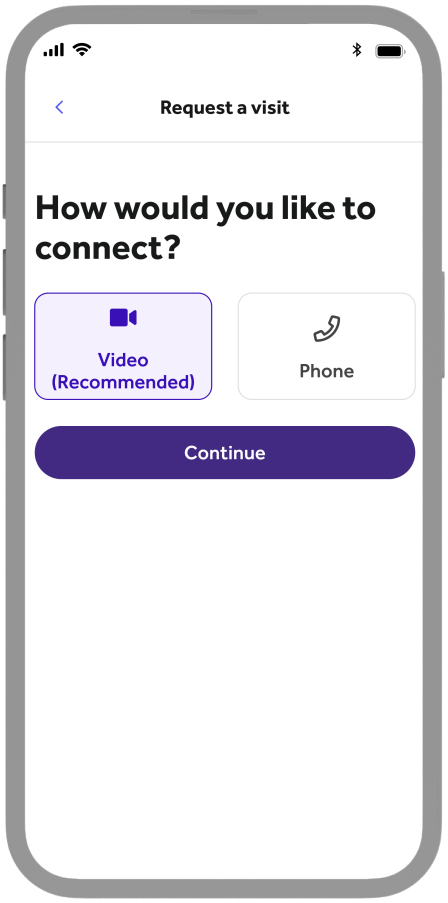

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Teladoc Health is not available internationally.

LANTERN

INDEPENDENT COLLEGES AND UNIVERSITIES ICUBA BENEFITS ASSOCIATION

Formerly Known As Surgery Plus Same Trusted Team

Lighting Your Path to the Right Surgical Care

What is Lantern?

Lantern can help you get the best care when you need planned, nonemergency surgery. This money-saving benefit is available at no additional cost to you as part of your benefits.

Here's What's Covered

In partnership with ICUBA, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your Lantern benefit. Your coverage includes:*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

Let Us Guide You Back to Health

3 Steps to the Best Care

STEP 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

STEP 2

Based on your needs, your Care Advocate will match you with a hand-picked list of excellent surgeons.

STEP 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

Call Us to Learn More at 855 200 2119

* Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

LANTERN

INDEPENDENT COLLEGES AND UNIVERSITIES ICUBA BENEFITS ASSOCIATION

Anteriormente Conocido Como Surgery Plus · Mismo Equipo de Confianza

Iluminando Su Camino a la Atención Quirúrgica Adecuada

¿Qué es Lantern?

Lantern puede ayudarlo a obtener la mejor atención cuando necesite una cirugía planificada que no sea de emergencia. Este beneficio de ahorro de dinero está disponible sin costo adicional para usted como parte de sus beneficios.

Lo Que Está Cubierto

En colaboración con ICUBA cubrimos los costos más elevados de la cirugía, por lo que pagará menos por el procedimiento cuando utilice el beneficio de Lantern. La cobertura incluye lo siguiente:*

- Apoyo y guía dedicados
- Asignación personalizada al cirujano que mejor se adapte a sus necesidades
- Consultas y citas con su cirujano de Lantern
- Tarifas de anestesia, procedimientos y establecimiento (hospital)

Permítanos Devolverle Su Salud

3 Pasos para Recibir la Mejor Atención

PASO 1

Llame a un defensor de atención para comenzar. Le compartirá más información sobre sus beneficios y le preguntará sobre la atención que está buscando.

PASO 2

En función de sus necesidades, su defensor de atención le asignará una lista cuidadosamente seleccionada de excelentes cirujanos.

PASO 3

Después de elegir un cirujano, su defensor de atención lo ayudará a programar citas y lo guiará en cada paso de la experiencia.

Llámanos al 855 200 2119

* Es posible que no se incluyan los gastos de pruebas, exámenes, diagnósticos por imágenes, equipos médicos durables y fisioterapia. Sin embargo, pueden estar cubiertos por su plan médico.

En caso de una emergencia médica, llame al 911 o visite la sala de emergencias más cercana.

Your partner for pain relief

With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best.

Specialized care, personalized for you

Reduce everyday joint and muscle aches. Recover from an injury. Relieve pelvic pain and discomfort.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Access to Hinge Health Enso® a non-addictive, FDA-cleared wearable device to calm and soothe pain flare-ups in minutes

$0
cost to you

Scan the QR code or visit:
hinge.health/icuba-join

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

A HINGE HEALTH EXCLUSIVE

Meet Enso

The small device for pain relief on-the-go.

*Eligibility to receive Hinge Health Enso is based on the program in which you are placed, fulfillment of clinical eligibility criteria, and completion of a qualifying number of exercise sessions.

Members and dependents 18+ enrolled in a Blue Cross Blue Shield ICUBA medical plan are eligible.

BlueCross BlueShield Global | Core

Healthcare coverage when you are traveling or living abroad

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

To take advantage of the program:

- Always carry your current member ID card.
- Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details. Coverage outside the United States may be different.
- If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
- If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. *Note: This number is different from the phone number listed below.*
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at www.bcbsglobalcore.com.

In an emergency, go directly to the nearest hospital.

To learn more about Blue Cross Blue Shield Global Core:

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

16-581-N35