

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 EPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Healthcare Coverage Summary		
Deductible Per Benefit Period (PBP)		
Individual	\$3,000	Not Covered
Family	\$6,000	
Coinsurance	20%	Not Covered
Out-of-Pocket Maximums PBP		
Individual	\$7,400	Not Covered
Family	\$14,800	
Lifetime Maximum	No Maximum	
Physician Office Visits <i>(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)</i>	\$15 copay (not subject to deductible)	Not Covered
Total Care Physician Office Visit <i>(Internist, Family Practice, Pediatrician)</i>	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 <i>(initial OB visit only)</i>	\$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	0% (not subject to deductible)	Not Covered
Outpatient Facility (Hospital setting) ²	20% coinsurance	
Preventive Care <i>Annual Physical and Gynecological exam</i>	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 <i>Glucose Test, Lipid Panel, Cholesterol, and ALT/AST</i>	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services <i>(e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)</i>	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) <i>Minute Clinic- CVS/Healthcare Clinic - Walgreens</i>	0% after \$10 copay	Not Covered
Urgent Care Center	0% after \$30 copay	Not Covered
Hospital Expenses Inpatient	20% after deductible	Not Covered
Outpatient ³ <i>Services require pre-authorization</i>	20% after deductible	Not Covered
Outpatient Surgery Office Setting <i>(Physician or Specialist)</i>	20% (not subject to deductible)	Not Covered
Outpatient Facility	20% after deductible	Not Covered
Related professional services	20% 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
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
Infertility Services <i>(Counseling and testing to diagnose only)</i>	20% after deductible	Not Covered
Outpatient Physical Therapy	\$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	Not Covered
Outpatient Speech Therapy <i>(Restorative services only)</i>	\$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 <i>(X-Ray and other tests)</i>	20% after deductible	Not Covered
Outpatient Diagnostic Imaging ³ <i>(MRI, MRA, CAT Scan, PET Scan)</i> <i>Services require pre-authorization</i>	Allowed Charges up to \$500 Copay	Not Covered
Durable Medical Equipment	20% after deductible	Not Covered
Prosthetic Appliances	20% after deductible	Not Covered
Hearing Care Services		
Hearing aid screening/exam	20% (not subject to deductible)	Not Covered
Hearing aid	20% after in-network deductible Combined limit: \$1,500/ benefit period	Not Covered
Temporomandibular Joint Disorder <i>(Medical necessity required; excludes appliances and orthodontic treatment)</i>	20% after deductible	Not Covered
Inpatient Rehabilitation ³ <i>Services require pre-authorization</i>	20% after deductible Limit: 60 days/ benefit period	Not Covered
Skilled Nursing Rehabilitation	20% after deductible Limit: 60 days/ benefit period	Not Covered
Home Health Care ³ <i>Services require pre-authorization</i>	20% after deductible	Not Covered
Private Duty Nursing	20% after deductible	Not Covered
Hospice: Inpatient and Outpatient ³ <i>Services require pre-authorization</i>	0% (not subject to deductible)	Not Covered
Mental Health and Substance Abuse Coverage Summary		
Mental Health or Substance Abuse Inpatient	20% after deductible	Not Covered
Outpatient	\$15 copay (not subject to deductible)	Not Covered
Inpatient ³ <i>Services require pre-authorization</i>	20% after deductible	Not Covered
Mental Health Hospital Admission ³ <i>Services require pre-authorization</i>	20% after deductible	Not Covered
Substance Abuse Hospital Admission ³ <i>Services require pre-authorization</i>	20% 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. <i>Services require pre-authorization</i>	20% 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. <i>Services require pre-authorization</i>	20% 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
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
Applied Behavioral Analysis Therapy ³ Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis. <i>Services require pre-authorization</i>	\$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. <i>Services require pre-authorization</i>	\$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 <i>Tier 1 Medications on the Premium Formulary</i>	\$10 copayment	\$20 copayment
Preferred Brand: ⁶ <i>Tier 2 Medications on the Premium Formulary</i>	\$55 copayment	\$110 copayment
Non-Preferred Brand: ⁶ <i>Tier 3 Medications on the Premium Formulary</i>	\$95 copayment	\$190 copayment
Preferred Specialty Medication ⁷ <i>Required to use Optum Specialty Pharmacy</i>	20% coinsurance not to exceed \$500 per covered prescription	
Non-Preferred Specialty Medication ⁷ <i>Required to use Optum Specialty Pharmacy</i>	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



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.ccilo.cms.gov or call 1-855-258-9029 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network \$8,600 person/ \$17,200 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.MyHealthToolkitFL.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> .	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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	Teladoc visits are covered with a \$5 <u>Copay</u> . In-Network allergy injections/testing and labs are covered at No Charge. Convenient care clinics are covered with a \$10 <u>Copay</u> .
	<u>Specialist</u> visit	\$35 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	In-Network allergy injections/testing and labs are covered at No Charge.
	<u>Preventive care/screening/immunization</u>	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 <u>provider</u> if the services needed are <u>preventive</u> . Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>Coinsurance</u>	Not Covered	In-Network independent labs are covered at No Charge.
	Imaging (CT/PET scans, MRIs)	\$500 <u>Copay</u> / test; <u>deductible</u> does not apply	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
If you need drugs to treat your illness or condition	Preferred Generic drugs	\$0 Copay/Prescription (retail 30 and 90-day at NSU pharmacy, NCPDP# 1082041)	Not Covered	Retail 30: 30 day supply; Retail 90: 84-91 day supply; Mail Order: 84-91 day supply
		\$5 Copay/Prescription (retail 30-day)		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.
		\$10 Copay/Prescription (retail 90-day)		
More information about prescription drug coverage is available at www.MyHealthToolkitFL.com		\$10 Copay/Prescription (mail order)		
	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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required for some outpatient surgeries.
	Physician/surgeon fees	30% <u>Coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>Copay</u> / visit; <u>deductible</u> does not apply	\$500 <u>Copay</u> / visit; <u>deductible</u> does not apply	<u>Copayment</u> will be waived if admitted.
	<u>Emergency medical transportation</u>	\$250 <u>Copay</u> ; <u>deductible</u> does not apply	\$250 <u>Copay</u> ; <u>deductible</u> does not apply	
	<u>Urgent care</u>	\$30 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required.
	Physician/surgeon fees	30% <u>Coinsurance</u>	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you are pregnant	Office visits	\$15 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	<u>Pre-authorization</u> for facility services is required. <u>Copay</u> applies to the initial visit only. All subsequent office maternity services are covered at No Charge. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% <u>Coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	30% <u>Coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>Coinsurance</u>	Not Covered	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	<u>Rehabilitation services</u>	\$20 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	
	<u>Habilitation services</u>	\$20 <u>Copay</u> / visit; <u>deductible</u> does not apply	Not Covered	
	<u>Skilled nursing care</u>	30% <u>Coinsurance</u>	Not Covered	
	<u>Durable medical equipment</u>	30% <u>Coinsurance</u>	Not Covered	
	<u>Hospice services</u>	No Charge	Not Covered	
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 <u>excluded services</u>.)			
• 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 <u>plan document</u>.)			
• 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:

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:

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	
<u>Deductibles</u>	\$4,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,970

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,660

Cost Sharing	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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@hrcpliance.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 đỡ 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 건보함에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락주시요. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulingan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wilka nang walang gastos. Upang makausap ang isang tagasalín, 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 يساعدك أسئلة بخصوص خطة الصحة هذه، فإليك الحق في الحصول على المساعدة والمعلومات الضرورية ببلتلك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun **W** ap ede gen kesyon konsen nan plan sante sa a, se dwa w pou resewwa 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 êtes en train d'aider, a des quest ions apropos de ce plan medical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue a aucun coOt. Pour parler a un interprete, appelez 1-844-396-0190 . (French)

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

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

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

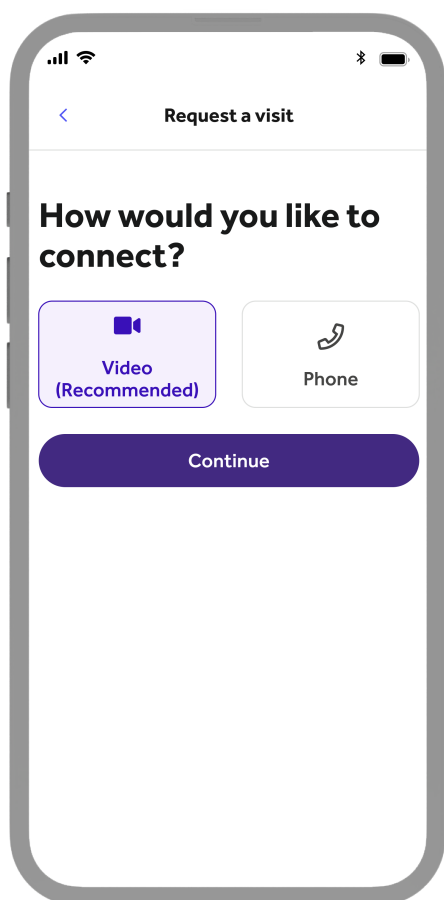
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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer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

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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



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.



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

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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
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- 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

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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.



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cost to you



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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.



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®.

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