The 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 care 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 visit http://icubabenefits.org or by calling 1-866-377-5102. 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?	**$3,000** *in-network per person;* **$6,000** *family/***$4,500** *out-of-network per person;* **$11,750** *family.*	*You must pay all of 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. The deductible starts over each April 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.*
Are there services covered before you meet your deductible?	*Yes. Deductible doesn't apply to in-network: preventive care, Teladoc, office visits, prescription drugs, outpatient facility labs, or advanced imaging. Doesn't apply to in- or out-of-network: emergency room, urgent care, convenient care, or emergency transportation.*	*This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.*
Are there other deductibles for specific services?	*No.*	*You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.*
What is the out-of-pocket limit for this plan?	**$7,400** *in-network per person;* **$14,800** *family/* **$10,900** *out-of-network per person/* **$21,800** *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 http://myhealthtoolkitfl.com, contact Essential Advocate at 1-888-521-2583 or call BCBS customer service at 1-855-258-9029 for a list of network providers.*	*This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. See the chart starting on page 2 for how this plan pays different kinds of providers.*
Do you need a referral to see a specialist?	*No.*	*You can see the specialist you choose without permission from this plan.*

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
		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 (No Deductible)	*Primary care visit to treat an injury or illness*	*$15 Copayment//Visit*	*Deductible + 40% Coinsurance*	*Additional cost shares may apply for physician administered drugs.* *Embold Health Primary Care, Pediatrician, Cardiology, Dermatology, Endocrinology, Ortho Joint-Spine, Gastroenterology, Neurology, Obstetrics and Gynecology, Podiatry, Pulmonology, Ophthalmology, Urology, General, Bariatric and Lung Cancer surgery. (Orthopedic/Neurosurgical). Visits Are Always Free.* *Therapy and Chiropractic visits are limited to 60 each per Plan Year.*
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	*$0 Copayment/Visit*	*Not Applicable*	
	Embold Health	*$0 Copayment/Visit*	*Not Covered*	
	Specialist *visit*	*$35 Copayment/Visit*	*Deductible + 40% Coinsurance*	
	Convenient Care Clinic	*$10 Copayment/Visit*	*$10 Copayment/Visit*	
	Physical/Occupational/Speech Therapy and Chiropractor Visits	*$20 Copayment/Visit*	*Deductible + 40% Coinsurance*	
	Preventive care/screening/ immunization	*No Charge*	*Not Covered*	*You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Diagnostic test (blood work)	*$0 for Quest Diagnostic Laboratories; 20% Coinsurance for clinical outpatient facility labs*	*Deductible + 40% Coinsurance*	*Must be medically necessary.*
If you have a test	*X-Ray*	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*None*
	Imaging (CT/PET scans, MRIs)	*$500 Copay (or actual cost if less) for family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility*	*Deductible + 40% Coinsurance family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility*	*Prior Authorization required.*
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.MyHealthToolkitFL.com** **(No Deductible)** *Out of pocket limit is $2,000 in-network for individual, $4,000 family. No limit for out-of-network.*	*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)*	*40% Coinsurance (after payment in full and filing paper claim for reimbursement)*	**Retail 30:** *30 day supply;* **Retail 90:** *84-91 day supply;* **Mail Order:** *84–91 day supply* **Specialty Drugs:** *Certain medications used for treating complex health conditions must be obtained through the specialty pharmacy program. Manufacturer coupons may not be applied to copay for non-preferred specialty drugs.* *Prescribed preventive generic medications to treat one of the conditions designated Essential Health*
	Non-Preferred Generic drugs	*$10 Copay/Prescription (retail 30-day)* *$20 Copay/Prescription (retail 90-day)* *$20 Copay/Prescription (mail order)*	*40% Coinsurance (after payment in full and filing paper claim for reimbursement)*	
	Preferred brand drugs	*$55 Copay/Prescription (retail 30-day)* *$110 Copay/Prescription (retail 90-day)* *$110 Copay/Prescription (mail order)*	*40% Coinsurance (after payment in full and filing paper claim for reimbursement)*	
	Non-Preferred brand drugs	*$95 Copay/Prescription (retail 30-day)* *$190 Copay/Prescription (retail 90-day)* *$190 Copay/Prescription (mail order)*	*40% Coinsurance (after payment in full and filing paper claim for reimbursement)*	
	Preferred Specialty drugs	*20% coinsurance not to exceed $500 per prescription.*	*40% Coinsurance (after payment in full and filing*	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			paper claim for reimbursement)	*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 Specialty drugs	*20% coinsurance not to exceed $500 per prescription.*	*40% Coinsurance (after payment in full and filing paper claim for reimbursement)*	
If you have outpatient surgery (Must meet Deductible)	*Facility fee (e.g., ambulatory surgery center)*	*Deductible + 20% Coinsurance for Outpatient Hospital Facility*	*Deductible + 40% Coinsurance for Outpatient Hospital Facility*	*None*
	Physician/surgeon fees	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*None*
If you need immediate medical attention (No Deductible)	*Emergency room care*	*$500 Copayment*	*$500 Copayment*	*Waived if Admitted*
	Emergency medical transportation	*$250 Copayment*	*$250 Copayment*	*None*
	Urgent care	*$30 Copayment/Visit*	*$30 Copayment/Visit*	*None*
	Teladoc Telemedicine	*$5 Copayment/Visit*	*Not Covered*	*None*
If you have a hospital stay (Must meet Deductible)	*Facility fee (e.g., hospital room)*	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per benefit period.*
	Physician/surgeon fees	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*None*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services *Inpatient:* **(Must Meet Deductible)** *Outpatient:* **(No Deductible)** **For more information on Behavioral Health and Substance Abuse call: 1-800-868-1032**	*Outpatient services*	*$15 Copayment/Visit*	*Deductible + 40% Coinsurance*	*None*
	Inpatient services	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per Plan Year*
If you are pregnant **(In-network: Full deductible not required until delivery)**	*Prenatal and postnatal care*	*$15 Copayment (Initial Visit Only)*	*Deductible + 40% Coinsurance*	*None*
	Childbirth/delivery and all facility services	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	
If you need help recovering or have other special health needs	*Home health care*	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*Prior Authorization required*
	Rehabilitation services	*$20 Copayment/Visit 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 per benefit period. Includes physical therapy, speech therapy, and occupational therapy.*
	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*	*Up to 60 visits per benefit period*
	Durable medical equipment	*Deductible + 20% Coinsurance*	*Deductible + 40% Coinsurance*	*Prior Authorization required*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	*No Charge*	*Deductible + 40% Coinsurance*	*None*
If your child needs dental or eye care	*Children's eye exam*	*Covered under Vision Plan*	*See Vision Plan*	*See Vision Plan*
	Children's glasses	*Covered under Vision Plan*	*See Vision Plan*	*See Vision Plan*
	Children's dental check-up	*Covered under Dental Plan*	*See Dental Plan*	*See Dental Plan*

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- *Acupuncture*
- *Long-Term Care*
- *Weight loss programs*
- *Cosmetic surgery*
- *Routine Eye Care*
- *Infertility treatments*
- *Dental care*
- *Routine Foot Care unless for treatment of diabetes*

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- *Diagnosis of Infertility*
- *Bariatric Surgery with prior authorization*
- *Chiropractic Care*
- *Coverage provided outside the United States. See www.bluecardworldwide.com*
- *Hearing Aids*
- *Non-emergency care when traveling outside the United States*

Your Rights to Continue Coverage: *There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-258-9029. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact any or all of the following:*

- *1-855-258-9029 or visit us at www.MyHealthToolkitFL.com*
- *The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.

Language Access Services:
To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

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

Chinese:

如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo:

T'áá Dinéjí shił hane'go shiká i'doolwoł ninizingo éí Nidaalnishígíí Áká Anidaalwo'igíí, customer service, bich'į' hodiilnih. Bik'ehgo bich'į' hane'igíí éí díí naaltsoos neiyí'niligíí akáa'gi siltsoozígíí bikáá' íishjáąh.

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

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** **$3,000**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,991**

In this example, Peg would pay:

Cost Sharing	
Deductibles	*$3,000*
Copayments	*$35*
Coinsurance	*$1,370*
The total Peg would pay is	**$4,405**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,690**

In this example, Joe would pay:

Cost Sharing	
Deductibles	*$0*
Copayments	*$675*
Coinsurance	*$55*
The total Joe would pay is	**$730**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$2,187**

In this example, Mia would pay:

Cost Sharing	
Deductibles	*$183*
Copayments	*$500*
Coinsurance	*$155*
The total Mia would pay is	**$838**

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