Summary of PPO *Benefits*

Benefit Period April 1-March 31

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, 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 Premier Copay Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Deductible Per Benefit Period (PBP) **Individual** **Family**	 **$2,500** **$5,000**	 **$4,000** **$10,750**
Coinsurance	**20%**	**40%**
Out-of-Pocket Maximums PBP ***(includes deductible, coinsurance, and medical copays)*** **Individual** **Family**	 **$4,000** **$8,000**	 **$7,500** **$15,000**
Lifetime Maximum	**No Maximum**	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	**0% after $25 copay** (not subject to deductible)	**40% after deductible**
Blue Distinction Total Care Office Visit *(Internal Medicine, Family Practice, Pediatrician)*	**0%** (not subject to deductible or copayment)	**N/A**
Teladoc Telemedicine Visit	**0% after $5 copay**	**N/A**
Maternity Office Visit Benefit *(initial OB visit only)*	**0% after $25 copay** (not subject to deductible)	**40% after deductible**
Specialist Office Visits	**0% after $50 copay** (not subject to deductible)	**40% after deductible**
Independent Clinical Labs * (free standing facilities and office visits) **Outpatient Facility (Hospital setting) ****	**0%** (not subject to deductible) **20% coinsurance**	**40% after deductible**
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**

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

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

Effective 4/1/19

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Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee responsibility)	
Allergy Injections	**0%** (not subject to deductible)	**40% after deductible**
Emergency Room Services	**0% after $300 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**	
Urgent Care Center	**0% after $50 copay**	
Hospital Expenses		
Inpatient	**20% after deductible**	**40% after deductible**
Outpatient	**20% after deductible**	**40% after deductible**
Outpatient Surgery Office Setting		
Physician Specialist	**0% after $25 copay** **0% after $50 copay**	**40% after deductible**
Outpatient Facility	**20% after deductible**	**40% after deductible**
Related professional services	**20% after deductible**	**40% after deductible**
Non-Emergent Surgeries with SurgeryPlus *Please call 1-855-200-2119 for this separate benefit*	*Deductible and coinsurance is waived when utilizing SurgeryPlus services and network*	***Not Covered***
Infertility Services (Counseling and testing to diagnose only)	**20% after deductible**	**40% after deductible**
Outpatient Physical Therapy ***	**0% after $30 copay**	**40% after deductible**
	Limit: 30 visits/ benefit period	
Outpatient Speech Therapy *** (Restorative services only)	**0% after $30 copay**	**40% after deductible**
	Limit: 30 visits/ benefit period	
Outpatient Occupational Therapy	**0% after $30 copay**	**40% after deductible**
	Limit: 30 visits/ benefit period	
Spinal Manipulation	**0% after $30 copay**	**40% after deductible**
	Limit: 60 visits/ benefit period	
Diagnostic Services (X-Ray and other tests)	**20% after deductible**	**40% after deductible**
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	**Allowed Charges up to $500 Copay**	**40% after deductible**
Durable Medical Equipment	**20% after deductible**	**40% after deductible**
Prosthetic Appliances	**20% after deductible**	**40% after deductible**
Hearing aid screening/exam	**20%** (not subject to deductible)	
Hearing aid	**20% after in-network deductible**	
	Combined limit: $1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	**20% after deductible**	**40% after deductible**
Inpatient Rehabilitation	**20% after deductible**	**40% after deductible**
	Limit: 60 days/ benefit period	
Skilled Nursing Rehabilitation	**20% after deductible**	**40% after deductible**
	Limit: 60 days/ benefit period	
Home Health Care	**20% after deductible**	**40% after deductible**
Private Duty Nursing	**20% after deductible**	**40% after deductible**
Hospice (Inpatient and Outpatient Care)	**0%** (not subject to deductible)	**40% after deductible**
Mental Health, Substance Abuse Benefits are provided by Aetna Behavioral Health - Available 24 hours at 877-398-5816		
Mental Health/Substance Abuse		
Inpatient	**20% after deductible**	**40% after deductible**
Outpatient	**0% after $25 copay**	**40% after deductible**

*** Up to 60 visits/benefit period combined with occupational therapy.

Note on Out-of-Network Providers: Services rendered by an out-of-network provider may be subject to balance billing by the out-of-network provider for the difference between the allowed amount and provider billed charges. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. Please see your Plan Document for detailed information on plan terms and the appeals process.

Effective 4/1/19