

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

Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
Deductible Per Benefit Period (PBP)		
Individual	\$2,000	\$3,500
Family	\$4,000	\$9,750
Coinsurance	20%	40%
Out-of-Pocket Maximums PBP <i>(includes deductible, coinsurance, and medical copays)</i>		
Individual	\$3,500	\$7,000
Family	\$7,000	\$14,000
Lifetime Maximum	No Maximum	
Physician Office Visits <i>(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)</i>	20% (not subject to deductible)	40% after deductible
Blue Distinction Total Care Office Visit <i>(Internal Medicine, Family Practice, Pediatrician)</i>	0% (not subject to deductible or copayment)	N/A
Teladoc Telemedicine Visit	\$5 copay	N/A
Maternity Office Visit Benefit <i>(initial OB visit only)</i>	\$20 copay (not subject to deductible)	40% after deductible
Specialist Office Visits	20% (not subject to deductible)	40% after deductible
Independent Clinical Labs ** <i>(free standing facilities and office visits)</i>	0% (not subject to deductible)	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.

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed as Employee responsibility)</i>	
Allergy Injections	0% (not subject to deductible)	40% after deductible
Emergency Room Services	0% after \$300 copay (waived if admitted)	
Medically Necessary Emergency Transportation	\$250 copay	
Convenient Care Clinic (Retail) Minute Clinic- CVS/Healthcare Clinic - Walgreens	0% after \$10 copay	
Urgent Care Center	0% after \$30 copay	
Hospital Expenses		
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Outpatient Surgery Office Setting (Physician or Specialist)	20% (not subject to deductible)	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Related professional services	20% after deductible	40% after deductible
Infertility Services (Counseling and testing to diagnose only)	20% after deductible	40% after deductible
Outpatient Physical Therapy ***	20% (not subject to deductible)	40% after deductible
	Limit: 30 visits/ benefit period	
Outpatient Speech Therapy *** (Restorative services only)	20% (not subject to deductible)	40% after deductible
	Limit: 30 visits/ benefit period	
Outpatient Occupational Therapy	20% (not subject to deductible)	40% after deductible
	Limit: 30 visits/ benefit period	
Spinal Manipulation	20% (not subject to 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)	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Prosthetic Appliances	20% after deductible	40% after deductible
Hearing Care Services		
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	20% (not subject to deductible)	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.



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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-258-9029 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 in-network per person; \$4,000 family/ \$3,500 out-of-network per person; \$9,750 family.	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 1 st . 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, office visits, Teladoc, or prescription drugs. 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?	\$3,500 in-network per person; \$7,000 family/ \$7,000 out-of-network per person/ \$14,000 family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	The out-of-pocket limit is the most you could pay 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.

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 6, 2016



 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 <u>provider's</u> office or clinic (No Deductible)	Primary care visit to treat an injury or illness	20% Coinsurance/Visit	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs.
	<u>Specialist</u> visit	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	Convenient Care Clinic	\$10 Copayment/Visit	\$10 Copayment/Visit	Blue Distinction Total Care Primary Care Provider (internal medicine, family medicine and pediatric medicine) Visits Are Always Free.
	Other practitioner office visit	20% Coinsurance/Visit	Deductible + 40% Coinsurance	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	
<u>Diagnostic test</u> (blood work)	\$0 for Quest Diagnostic Laboratories	Deductible + 40% Coinsurance for clinical labs other than Quest	Quest Diagnostic is the exclusive provider of in-network laboratory services.	
If you have a test (Must meet Deductible)	X-Ray	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance 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.

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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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com</p> <p>(No Deductible)</p> <p>Out of pocket limit is \$2,000 in-network for individual, \$4,000 family. No limit for out-of-network.</p>	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)	<p>Retail 30: Up to 30 day supply; Retail 90: 84-91 day supply; Mail Order: 84-91 day supply</p> <p>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.</p>
	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	\$40 Copay/Prescription (retail 30-day) \$80 Copay/Prescription (retail 90-day) \$80 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred brand drugs	\$75 Copay/Prescription (retail 30-day) \$150 Copay/Prescription (retail 90-day) \$150 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Preferred Specialty drugs	\$75 Copay/Prescription (Briova 30-day) Manufacturer coupons accepted.	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred Specialty drugs	\$75 Copay/Prescription (Briova 30-day)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
<p>If you have outpatient surgery (Must meet Deductible)</p>	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

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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 immediate medical attention (No Deductible)	Emergency room care	\$300 Copayment	\$300 Copayment	Waived if Admitted
	Emergency medical transportation	\$250 Copayment	\$250 Copayment	None
	Urgent care	\$30 Copayment/Visit	\$30 Copayment/Visit	None
	Teladoc	\$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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	Deductible + 40% Coinsurance	None
	Inpatient: (Must Meet Deductible) Outpatient: (No Deductible)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Limited to 60 days per benefit period
For more information on Behavior Health and Substance Abuse call: 1-877-398-5816				
If you are pregnant (In-network: Full deductible not required until delivery)	Prenatal and postnatal care	\$20 Copayment	Deductible + 40% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	

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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 help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Rehabilitation services	20% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Up to 30 visits per benefit period. Up to 60 combined visits per benefit period includes physical/occupational therapy, or speech/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 days per benefit period
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	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.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Long-Term Care • Weight loss programs | <ul style="list-style-type: none"> • Cosmetic surgery • Routine Eye Care • Infertility treatments | <ul style="list-style-type: none"> • Dental care • Routine Foot Care unless for treatment of diabetes |
|---|--|---|

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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 www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 Dinéji shil hane'go shiká i' doolwoł ninizingo éi Nidaalnishigii Áká Anidaalwo'igii, customer service, bich'í' hodíilnih. Bik'ehgo bich'í' hane'igii éi díi naaltsos neiyi'niligii akáa'gi siltsoozigii bikáá' iishjááh.


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

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

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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](#) \$2,000
- [Specialist coinsurance](#) 20%
- [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$20
Coinsurance	\$1,470
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,550

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist coinsurance](#) 20%
- [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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$675
Coinsurance	\$55
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$785

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist coinsurance](#) 20%
- [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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$183
Copayments	\$300
Coinsurance	\$155
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$638