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**	 **$2,000** **$4,000**	 **$3,500** **$9,750**
Coinsurance	**20%**	**40%**
Out-of-Pocket Maximums PBP ***(includes deductible, coinsurance, and medical copays)*** **Individual** **Family**	 **$3,500** **$7,000**	 **$7,000** **$14,000**
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	**$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)	**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.

ICUBA Premier Copay Plan

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**
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**	
	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	**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 4/1/17

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 for covered services you use. 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, 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.

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	$25 Copayment/Visit	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs. Blue Distinction Total Care Primary Care Provider (internal medicine, family medicine and pediatric medicine) Visits Are Always Free.
	Specialist visit	$50 Copayment/Visit	Deductible + 40% Coinsurance	
	Convenient Care Clinic	$10 Copayment/Visit	$10 Copayment/Visit	
	Other practitioner office visit	$30 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.
	Diagnostic test (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.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.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:** Up to 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)	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)	
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

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	$50 Copayment/Visit	$50 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 Inpatient: **(Must Meet Deductible)** Outpatient: **(No Deductible)** **For more information on Behavior Health and Substance Abuse call: 1-877-398-5816**	Outpatient services	$25 Copayment/Visit	Deductible + 40% Coinsurance	None
	Inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Limited to 60 days per benefit period.
If you are pregnant **(In-network: Full deductible not required until delivery)**	Prenatal and postnatal care	$25 Copayment	Deductible + 40% Coinsurance	None
	Childbirth/delivery and all facility services	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 help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Rehabilitation services	$30 Copayment 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.)

- 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 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 Dinéjí shił hane'go shiká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyi'nilígíí akáa'gi siltsoozígíí bikáá' íishjáá́h.

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	$2,000
Specialist copayment	$50
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	$2,000
Copayments	$25
Coinsurance	$1,470
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,555**

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 copayment	$50
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	$775
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$830**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
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	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$703**

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