



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 **1-800-830-1501**. 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 **1-800-830-1501** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-Network \$3,400 person/ \$6,800 family. Out-of-Network \$6,800 person/ \$13,600 family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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. In-Network <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 \$6,550 person/ \$13,100 family. Out-of-Network \$13,100 person/ \$26,200 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> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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
		In-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	Primary care visit to treat an injury or illness	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Teladoc visits are covered and will bypass deductible. (General Medical \$0, PCP \$10, Mental Health \$20 and Dermatology \$20). Convenient Care Centers are covered.
	<u>Specialist visit</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Nutritional counseling limited to 6 visits/benefit year
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coinsurance</u>	See www.healthcare.gov for <u>preventive care</u> guidelines. There may be additional benefits available. See your Employer for details. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	In-Network labs/x-ray performed at a free-standing facility are covered with 0% <u>Coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<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 More information about <u>prescription drug coverage</u> is available at www.MyHealthToolkitFL.com	Generic drugs (Retail)	\$15 <u>Copay</u> / prescription	Not Covered	31 day supply.
	Generic drugs (Mail Order)	\$37.50 <u>Copay</u> / prescription	Not Covered	90 day supply.
	Preferred brand drugs (Retail)	\$35 <u>Copay</u> / prescription	Not Covered	31 day supply.
		\$87.50 <u>Copay</u> / prescription	Not Covered	90 day supply.
	Non-preferred brand drugs (Retail)	\$60 <u>Copay</u> / prescription	Not Covered	31 day supply.
	Non-preferred brand drugs (Mail Order)	\$150 <u>Copay</u> / prescription	Not Covered	90 day supply.
	<u>Specialty drugs</u>	\$60 <u>Copay</u> / prescription	Not Covered	31 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> is required for some outpatient surgeries. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network. Varicose vein treatments are limited to \$2,500/benefit year.
	Physician/surgeon fees	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>Coinsurance</u>	30% <u>Coinsurance</u>	None
	<u>Emergency medical transportation</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
	<u>Urgent care</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network.
	Physician/surgeon fees	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network.
	Substance use disorder outpatient services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
	Mental/behavioral health inpatient services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network.
	Substance use disorder inpatient services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
If you are pregnant	Office visits	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> for facility services is required. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network. Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	120 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	<u>Rehabilitation services</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	60 combined visits/benefit year for Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic services.
	<u>Habilitation services</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	60 combined visits/benefit year for Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic services.
	<u>Skilled nursing care</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	100 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is \$400 Out-of-Network.
	<u>Durable medical equipment</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Purchase or rentals of \$500 or more require <u>pre-authorization</u> . Penalty for not obtaining <u>pre-authorization</u> is denial of all charges. Hearing aids are limited to \$5,000/every 2 years.
	<u>Hospice services</u>	30% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges for In-Network Outpatient and all Out-of-Network services.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam/every 24 months.
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic Surgery	• Dental Care (Child)	• Routine Foot Care
• Dental Care (Adult)	• Long-Term Care	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture, limited to \$800/benefit year	• Hearing Aids	• Private-Duty Nursing, limited to 70 visits/benefit year
• Bariatric Surgery, limited to \$20,000/benefit year	• Infertility Treatment, diagnosis/testing/treatment of underlying condition assisted reproduction \$10,000 lifetime max	• Routine Eye Care (Adult)
• Chiropractic Care, 60 visits/benefit year combined with other therapies	• Non-emergency care when traveling outside the U.S.	• Routine Eye Care (Child)

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: 1-800-830-1501 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:

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 shíł hane'go shiká i'doolwoł nínizingo éi Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'í' hodiilnih. Bik'ehgo bich'í' hane'ígíí éi díi naaltsoos neiyi'níligíí akáa'gí sítsoozígíí bikáá' íishjááh.

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

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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 (TDD: 711).

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 by emailing contact@hcrcompliance.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 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 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, 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 تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك 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 konsenan plan sante sa a, se dwa w pou resevwa 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 etes en train d'aider, avez des questions apropos de ce plan medical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler a un interprete, appelez le 1-844-396-0190. (French)

Jesli Ty lub osoba, ktorej pomagasz, macie pytania odnosnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezptatnej informacji i pomocy we wtasnym jzyku. Aby porozmawiac z tłumaczem, zadzwon pod numer 1-844-396-0186. (Polish)

Se voce, ou alguem a quern voce esta ajudando, tern perguntas sobre este piano de saude, voce tern o direito de obter ajuda e informaao 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 ii 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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Nida doodago t'aa haida bika'ana nilwo'igii dii Beeso Ach'□□h naa'niligi haa'ida yi na' idil kidgo, niha'ah66t'i' nihi ka'a'doo wolgo kwii ha'at'ishif bi na'idolkidigi doo bik'e'azlaag66. Ata' halne'e la' bich'f ha desdzh ninizingo, koji' beesh bee h6lne' 1-844-516-6328. (Navajo)