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, www.[insert].com. 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 www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000** Per Person/**$3,000** Family. Out-of-Network: **$2,000** Per Person/**$6,000** Family.	Generally, 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.
Are there services covered before you meet your deductible?	Yes. Preventive care.	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$3,000** Per Person/**$6,000** Family. Out-Of-Network: **$5,000** Per Person/**$10,000** 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?	Premium, balance-billed 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 https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Primary care visit to treat an injury or illness	$25 Copay per Visit	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $50 Copay per Visit	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	$125 Copay per Visit	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $20 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$30 Copay per Prescription at retail, $60 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$60 Copay per Prescription at retail, $120 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are	Specialty drugs are subject	Not covered through Mail Order. Up to 30 day

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)	
		subject to the cost share based on applicable drug tier.	to the cost share based on the applicable drug tier.	supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 Copay per Visit/ Hospital Option 1: $150 Copay per Visit	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	$200 Copay per Visit	$200 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: $750 Copay per Admission	Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: Deductible + 20% Coinsurance / Hospital Opt 1: $150 Copay per Visit	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Inpatient services	Physician Services: Deductible + 20% Coinsurance / Hospital Opt 1: $750 Copay per Admission	Physician Services: In-Network Deductible + 20% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Option 2 hospitals may have a higher cost-share.
If you are pregnant	Office visits	Deductible + 20%	Deductible + 40%	Maternity care may include tests and services

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)	
		Coinsurance	Coinsurance	described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: $750 Copay per Day	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.