

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual and/or Family | Plan Type: PPO



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.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group). 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.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group) or call 1-800-352-2583 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | In-Network: <b>\$500</b> Per Person/ <b>\$1,500</b> Family. Out-of-Network: <b>\$1,500</b> Per Person/ <b>\$4,500</b> Family.                                                                                                  | Generally, you must pay all of 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. <u>Preventive care</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 certain <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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                    |
| 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 plan?               | In-Network: <b>\$3,000</b> Per Person/ <b>\$6,000</b> Family. Out-Of-Network: <b>\$6,000</b> Per Person/ <b>\$12,000</b> 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>Premium</u> , <u>balance-billed</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 <a href="https://providersearch.floridablue.com/providersearch/pub/index.htm">https://providersearch.floridablue.com/providersearch/pub/index.htm</a> or call 1-800-352-2583 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                                                                                                                                                                                           |
|---------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <u>Network Provider</u><br>(You will pay the least)                                                                                                                                             | <u>Out-of-Network Provider</u><br>(You will pay the most)                |                                                                                                                                                                                                                                                  |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | Value Choice Provider: No Charge, <u>Deductible</u> does not apply/ Primary Care Visits: \$25 <u>Copay</u> per Visit/ Virtual Visits: No Charge, <u>Deductible</u> does not apply               | <u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered | Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.                                                                                                                |
|                                                               | <u>Specialist</u> visit                          | Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Specialist: \$60 <u>Copay</u> per Visit/ Virtual Visits: \$60 <u>Copay</u> per Visit                                                      | <u>Deductible</u> + 50% <u>Coinsurance</u> / Virtual Visits: Not Covered | Physician administered drugs may have higher cost share. Virtual Visit services are <u>only</u> covered for In-Network providers.                                                                                                                |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge, <u>Deductible</u> does not apply                                                                                                                                                     | 50% <u>Coinsurance</u>                                                   | Physician administered drugs may have higher cost share. 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. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)       | Value Choice Specialist: \$20 <u>Copay</u> per Visit/ Independent Clinical Lab: No Charge, <u>Deductible</u> does not apply/ Independent Diagnostic Testing Center: \$50 <u>Copay</u> per Visit | <u>Deductible</u> + 50% <u>Coinsurance</u>                               | Tests performed in hospitals may have higher cost share.                                                                                                                                                                                         |
|                                                               | Imaging (CT/PET scans, MRIs)                     | <u>Deductible</u> + 20% <u>Coinsurance</u>                                                                                                                                                      | <u>Deductible</u> + 50% <u>Coinsurance</u>                               | Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.                                                                                                              |

| Common Medical Event                                                                                                                                                                                                                                                                                              | Services You May Need                          | What You Will Pay                                                                                                                                                      |                                                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                   |                                                | Network Provider<br>(You will pay the least)                                                                                                                           | Out-of-Network Provider<br>(You will pay the most)                                                              |                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide">https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide</a> | Generic drugs                                  | \$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail                                                                               | 50% <u>Coinsurance</u>                                                                                          | 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 <u>Copay</u> per Prescription at retail, \$75 <u>Copay</u> per Prescription by mail                                                                               | 50% <u>Coinsurance</u>                                                                                          | Up to 30 day supply for retail, 90 day supply for mail order.                                                                                                           |
|                                                                                                                                                                                                                                                                                                                   | Non-preferred brand drugs                      | \$50 <u>Copay</u> per Prescription at retail, \$125 <u>Copay</u> per Prescription by mail                                                                              | 50% <u>Coinsurance</u>                                                                                          | Up to 30 day supply for retail, 90 day supply for mail order.                                                                                                           |
|                                                                                                                                                                                                                                                                                                                   | <u>Specialty drugs</u>                         | <u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.                                                                                    | <u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.                         | Up to 30 day supply for retail. Not covered through Mail Order.                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center) | <u>Deductible</u> + 20% <u>Coinsurance</u>                                                                                                                             | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                                      | —————none—————                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                   | Physician/surgeon fees                         | Ambulatory Surgical Center: \$60 <u>Copay</u> per Visit/ Hospital: \$100 <u>Copay</u> per Visit                                                                        | Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: \$100 <u>Copay</u> per Visit | —————none—————                                                                                                                                                          |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                    | <u>Emergency room care</u>                     | Physician Services: \$100 <u>Copay</u> per Visit/ Facility: \$300 <u>Copay</u> per Visit                                                                               | Physician Services: \$100 <u>Copay</u> per Visit/ Facility: \$300 <u>Copay</u> per Visit                        | —————none—————                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                   | <u>Emergency medical transportation</u>        | <u>Deductible</u> + 20% <u>Coinsurance</u>                                                                                                                             | <u>In-Network Deductible</u> + 20% <u>Coinsurance</u>                                                           | —————none—————                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                   | <u>Urgent care</u>                             | Value Choice Provider: No Charge, <u>Deductible</u> does not apply - Visits 1-2;\$65 <u>Copay</u> per remaining Visit/ Urgent Care Visits: \$65 <u>Copay</u> per Visit | <u>Deductible</u> + \$65 <u>Copay</u> per Visit                                                                 | —————none—————                                                                                                                                                          |
| <b>If you have a</b>                                                                                                                                                                                                                                                                                              | Facility fee (e.g., hospital                   | <u>Deductible</u> + 20% <u>Coinsurance</u>                                                                                                                             | <u>Deductible</u> + 50%                                                                                         | Inpatient Rehab Services limited to 30 days.                                                                                                                            |

For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](https://www.floridablue.com/plancontracts/group).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                            |                                                                                                   | Limitations, Exceptions, & Other Important Information                                                                                                                                           |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)                                                |                                                                                                                                                                                                  |
| hospital stay                                                             | room)                                     |                                              | <u>Coinsurance</u>                                                                                |                                                                                                                                                                                                  |
|                                                                           | Physician/surgeon fees                    | \$100 <u>Copay</u> per Visit                 | \$100 <u>Copay</u> per Visit                                                                      | —————none—————                                                                                                                                                                                   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No Charge, <u>Deductible</u> does not apply  | 50% <u>Coinsurance</u> / Specialist Virtual Visits: Not Covered                                   | Virtual Visit services are <u>only</u> covered for In-Network providers.                                                                                                                         |
|                                                                           | Inpatient services                        | No Charge, <u>Deductible</u> does not apply  | Physician Services: No Charge, <u>Deductible</u> does not apply/ Hospital: 50% <u>Coinsurance</u> | Prior Authorization may be required. Your benefits/services may be denied.                                                                                                                       |
| If you are pregnant                                                       | Office visits                             | \$60 <u>Copay</u> on initial Visit           | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                                                                  |
|                                                                           | Childbirth/delivery professional services | \$100 <u>Copay</u> per Visit                 | \$100 <u>Copay</u> per Visit                                                                      | —————none—————                                                                                                                                                                                   |
|                                                                           | Childbirth/delivery facility services     | <u>Deductible</u> + 20% <u>Coinsurance</u>   | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | —————none—————                                                                                                                                                                                   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | <u>Deductible</u> + 20% <u>Coinsurance</u>   | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | Coverage limited to 60 visits.                                                                                                                                                                   |
|                                                                           | <u>Rehabilitation services</u>            | \$60 <u>Copay</u> per Visit                  | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | 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. |
|                                                                           | <u>Habilitation services</u>              | Not Covered                                  | Not Covered                                                                                       | Not Covered                                                                                                                                                                                      |
|                                                                           | <u>Skilled nursing care</u>               | <u>Deductible</u> + 20% <u>Coinsurance</u>   | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | Coverage limited to 60 days.                                                                                                                                                                     |
|                                                                           | <u>Durable medical equipment</u>          | <u>Deductible</u> + 20% <u>Coinsurance</u>   | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.                                                                   |
|                                                                           | <u>Hospice services</u>                   | <u>Deductible</u> + 20% <u>Coinsurance</u>   | <u>Deductible</u> + 50% <u>Coinsurance</u>                                                        | —————none—————                                                                                                                                                                                   |
|                                                                           |                                           |                                              |                                                                                                   |                                                                                                                                                                                                  |
| If your child needs                                                       | Children's eye exam                       | Not Covered                                  | Not Covered                                                                                       | Not Covered                                                                                                                                                                                      |

For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group).

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| dental or eye care   | 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 <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> .)                          |                                                                                                                                                                                                |                                                                                                                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• <u>Habilitation services</u></li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Pediatric dental check-up</li> <li>• Pediatric eye exam</li> </ul> | <ul style="list-style-type: none"> <li>• Pediatric glasses</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care unless for treatment of diabetes</li> <li>• Weight loss programs</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                                             |                                                                                                                                                                                                |                                                                                                                                                                                                                                         |  |
| <ul style="list-style-type: none"> <li>• Chiropractic care - Limited to 35 visits</li> </ul>                                                                                                    | <ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.floridablue.com">www.floridablue.com</a>.</li> </ul>                        | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>                                                                                                                                  |  |

**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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa) or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

#### **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.

For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group).

**Does this plan meet the 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.

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

For more information about limitations and exceptions, see the plan or policy document at [www.floridablue.com/plancontracts/group](http://www.floridablue.com/plancontracts/group).

## 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 <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist Copayment</u>                 | \$60  |
| ■ Hospital (facility) <u>Coinsurance</u>      | 20%   |
| ■ Other <u>No Charge</u>                      | \$0   |

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*)

|                                   |                 |
|-----------------------------------|-----------------|
| <b>Total Example Cost</b>         | <b>\$12,700</b> |
| In this example, Peg would pay:   |                 |
| <u>Cost Sharing</u>               |                 |
| <u>Deductibles</u>                | \$500           |
| <u>Copayments</u>                 | \$200           |
| <u>Coinsurance</u>                | \$1,300         |
| <u>What isn't covered</u>         |                 |
| Limits or exclusions              | \$60            |
| <b>The total Peg would pay is</b> | <b>\$2,060</b>  |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist Copayment</u>                 | \$60  |
| ■ Hospital (facility) <u>Coinsurance</u>      | 20%   |
| ■ Other <u>Coinsurance</u>                    | 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*)

|                                   |                |
|-----------------------------------|----------------|
| <b>Total Example Cost</b>         | <b>\$5,600</b> |
| In this example, Joe would pay:   |                |
| <u>Cost Sharing</u>               |                |
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$1,400        |
| <u>Coinsurance</u>                | \$0            |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,400</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist Copayment</u>                 | \$60  |
| ■ Hospital (facility) <u>Coinsurance</u>      | 20%   |
| ■ Other <u>Copayment</u>                      | \$300 |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                                   |                |
|-----------------------------------|----------------|
| <b>Total Example Cost</b>         | <b>\$2,800</b> |
| In this example, Mia would pay:   |                |
| <u>Cost Sharing</u>               |                |
| <u>Deductibles</u>                | \$500          |
| <u>Copayments</u>                 | \$700          |
| <u>Coinsurance</u>                | \$100          |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.floridablue.com](http://www.floridablue.com).

### **Section 1557 Notification: Discrimination is Against the Law**

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

**Health and vision coverage (including FEP members):**

Section 1557 Coordinator  
4800 Deerwood Campus Parkway, DCC 1-7  
Jacksonville, FL 32246  
1-800-477-3736 x29070  
1-800-955-8770 (TTY)  
Fax: 1-904-301-1580  
section1557coordinator@floridablue.com

**Dental, life, and disability coverage:**

Civil Rights Coordinator  
17500 Chenal Parkway  
Little Rock, AR 72223  
1-800-260-0331  
1-800-955-8770 (TTY)  
civilrightscordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, by mail or phone at:

**U.S. Department of Health and Human Services**

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

**ATANSYON:** Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

**ATENÇÃO:** Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

**注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP: 請致電1-800-333-2227

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). اتصل برقم 1-800-333-2227.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.  
ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรศัพท์ 1-800-352-2583 (TTY: 1-800-955-8770) หรือ FEP โทร 1-800-333-2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583 (TTY: 1-800-955-8770) まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.  
یا شماره 1-800-352-2583 تماس بگیرید. FEP: یا شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojí' hodiíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojí' hodiíłnih 1-800-333-2227.

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