BlueOptions 05770

with Rx $10/$50/$80

Coverage Period: 11/01/2013 - 10/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual and/or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.floridablue.com or by calling 1-800-352-2583. In the event there is a conflict between this summary and your Florida Blue coverage documents the terms and conditions of the coverage documents will control.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$1,000** Per Person/**$3,000** Family. Out-Of-Network: **$3,000** Per Person/**$6,000** Family. Does not apply to In-Network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$3,500** Per Person/**$7,000** Family. Out-Of-Network: **$7,000** Per Person/**$14,000** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **participating providers**, see www.floridablue.com or call 1-800-352-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-352-2583 or visit us at www.floridablue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.floridablue.com or call 1-800-352-2583 to request a copy.

SBCID: 117926

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copayment	Deductible + 50% Coinsurance	Additional cost shares may apply for physician administered drugs.
	Specialist visit	$45 Copayment	Deductible + 50% Coinsurance	Additional cost shares may apply for physician administered drugs.
	Other practitioner office visit	$45 Copayment	Deductible + 50% Coinsurance	Additional cost shares may apply for physician administered drugs.
	Preventive care/ screening/immunization	No Charge	50% Coinsurance	Additional cost shares may apply for physician administered drugs.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Laboratory: No Charge Independent Diagnostic Testing Center: $50 Copayment Outpatient Hospital Option 1: Deductible + 20% Coinsurance Option 2: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Imaging (CT/PET scans, MRIs)	Physician Office: $200 Copayment Independent Diagnostic Testing Center: $200 Copayment Outpatient Hospital Option 1: Deductible + 20% Coinsurance Option 2: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com.	Generic drugs	$10 Copayment per prescription at retail, $25 Copayment per prescription by mail	50% Coinsurance	Covers up to 30 day supply at retail pharmacy. Covers up to 90 day supply for mail order. Responsible Rx programs such as Prior Authorization, Responsible Steps or Responsible Quantity may apply for each covered drug tier. Additional information can be found in the Medication Guide.
	Preferred brand drugs	$50 Copayment per prescription at retail, $125 Copayment per prescription by mail	50% Coinsurance	Covers up to 30 day supply at retail pharmacy. Covers up to 90 day supply for mail order.
	Non-preferred brand drugs	$80 Copayment per prescription at retail, $200 Copayment per prescription by mail	50% Coinsurance	Covers up to 30 day supply at retail pharmacy. Covers up to 90 day supply for mail order.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Covers up to 30 day supply at retail pharmacy. Specialty Drugs are not available through mail order Out-of-Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $150 Copayment Outpatient Hospital Option 1: Deductible + 20% Coinsurance Option 2: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Hospital: $100 Copayment Ambulatory Surgical Center: $45 Copayment	Hospital: $100 Copayment Ambulatory Surgical Center: Deductible + 50% Coinsurance	————none————
If you need immediate medical attention	Emergency room services	$200 Copayment	$200 Copayment	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Coverage is limited to $5,500 per day.
	Urgent care	$50 Copayment	Deductible + 50% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	$3,500 Copayment per admission	Inpatient Rehabilitation Services are limited to 21 days per benefit period.
	Physician/surgeon fee	$100 Copayment	$100 Copayment	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	50% Coinsurance	————none————
	Mental/Behavioral health inpatient services	No Charge	Physician Services: No Charge Inpatient Hospital: $500 Copayment per admission	————none————
	Substance use disorder outpatient services	No Charge	50% Coinsurance	————none————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder inpatient services	No Charge	Physician Services: No Charge Inpatient Hospital: $500 Copayment per admission	————none————
If you are pregnant	Prenatal and postnatal care	$45 Copayment	Deductible + 50% Coinsurance	————none————
	Delivery and all inpatient services	Physician Services: $100 Copayment Inpatient Hospital Option 1: Deductible + 20% Coinsurance Option 2: Deductible + 20% Coinsurance	Physician Services: $100 Copayment Inpatient Hospital: $3,500 Copayment per admission	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage is limited to 20 visits per benefit period.
	Rehabilitation services	Physician Office: $45 Copayment Outpatient Rehabilitation Center: $45 Copayment Outpatient Hospital Option 1: $45 Copayment Option 2: $60 Copayment	Deductible + 50% Coinsurance	Coverage is limited to 26 manipulations within 35 visits per benefit period.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage is limited to 60 days per benefit period.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
	Hospice service	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for 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

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care - Coverage limited to 26 manipulations within 35 visits per benefit period.
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-352-2583**. You may also contact your state insurance department at **1-877-693-5236**, 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**.

Your Grievance and Appeals Rights:

For more information on your rights to a grievance or appeal, contact the insurer at **1-800-352-2583**. You may also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform** ,or your state insurance department at **1-877-693-5236**.

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**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-352-2583**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-352-2583**.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-800-352-2583**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-352-2583**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,740
- **Patient pays** $1,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$100
Coinsurance	$500
Limits or exclusions	$200
Total	**$1,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,150
- **Patient pays** $1,250

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$70
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If the SBC includes both individual and family coverage tiers, the coverage examples were completed using the per-person deductible and out-of-pocket limit on page 1.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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