



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.floridablue.com/state-employees. 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 or call 1-800-825-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$250 Per Person/ \$500 Family. <u>Out-of-Network</u> : \$750 Per Person/\$1,500 Family. Does not apply to <u>preventive care</u>	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 care 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$250 <u>In-Network</u> Per Admission <u>Deductible</u> ; \$500 <u>Out-of-Network</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-Network</u> \$10,150 Per Person/ \$20,300 Family. <u>Out-of-Network</u> Unlimited Per Person/ Unlimited Per Family	This <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>in-network</u> 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 https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-825-2583 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</u> charge 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 <u>network</u> status with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral from this plan

 All [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	\$15 Copay per Visit	40% Coinsurance + amount above allowance	-----none-----
	Specialist visit	\$25 Copay per Visit	40% Coinsurance + amount above allowance	-----none-----
	Preventive care/screening/ Immunization	No Charge	Amount above allowance	Age and gender based.
	Telehealth (Virtual Visits)	\$15 Copay per Visit Primary care/ \$25 Copay per Visit Specialist	40% Coinsurance + amount above allowance	Limited to services provided through a two-way interactive device with both audio and visual communication.
	Teladoc®	\$0 Copay per Visit	Not Covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	-----none-----
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://welcome.optumrx.com/sofdms	Generic drugs	\$7 retail-30 day/\$14 mail/retail-90 day	You pay in full and file claim , you will not be reimbursed the full amount.	You are required to use mail order or a participating 90-day retail pharmacy for maintenance medications after three refills of a 30-day supply at a retail (30-day) pharmacy. Prior authorization required for some drugs to be covered by the Rx Plan . Must obtain through specialty pharmacy.
	Preferred brand drugs	\$30 retail-30 day/\$60 mail/retail-90 day		
	Non-preferred brand drugs	\$50 retail-30 day /\$100 mail/retail 90-day		
	Specialty drugs	\$14 Generic \$60 Preferred \$100 Non-preferred		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Does not cover cosmetic or non- medically necessary surgery or complications from such surgeries.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 Copay per Visit	\$100 Copay per Visit	-----none-----
	Emergency medical transportation	No Charge	No Charge	Must be medically necessary .
	Urgent care	\$25 Copay per Visit	\$25 Copay per Visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance + \$250 Per Admission Deductible	40% Coinsurance + \$500 Per Admission Deductible + amount above allowance	Admission Certification and Hospital Stay Certification required.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	-----none-----
	Inpatient services	Physician Services: Deductible + 20% Coinsurance Hospital: \$250 Per Admission Deductible + 20% Coinsurance	Physician Services: Deductible + 40% Coinsurance + amount above allowance Hospital: \$500 Per Admission Deductible + 40% Coinsurance + amount above allowance	Admission Certification and Hospital Stay Certification required.
If you are pregnant	Office visits	\$25 Copay per Visit	40% Coinsurance + amount above allowance	Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	-----none-----
	Childbirth/delivery facility services	Hospital: \$250 Per Admission Deductible + 20% Coinsurance	Hospital: \$500 Per Admission Deductible + 40% Coinsurance + amount above allowance	Admission Certification and Hospital Stay Certification required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Must meet criteria. Does not include speech therapy or custodial care. Occupational therapy is covered.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Physical therapy and massage therapy, 4 treatments per day, 21 treatment days per six-month period. Occupational therapy limited to 21 treatment days per six-month period.
	Habilitation services	Not Covered	Not Covered	-----none-----
	Skilled nursing care	30% Coinsurance	30% Coinsurance + amount above allowance	Limited to 60 days per calendar year. Does not include custodial care.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance + amount above allowance	Limited to the most standard model available to meet medical necessity.
	Hospice services	30% Coinsurance (inpatient) / 20% Coinsurance (outpatient/home)	30% Coinsurance (inpatient)/20% Coinsurance (outpatient/ home) + amount above allowance	Coverage limited to 210 days lifetime maximum per person/ occupational therapy is covered.
If your child needs dental or eye care	Children's eye exam	\$25 Copay	40% Coinsurance + amount above allowance	-----none-----
	Children's glasses	Not Covered	Not Covered	-----none-----
	Children's dental check-up	Not Covered	Not Covered	-----none-----

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](#).)

- | | | |
|---|---|---|
| • Cosmetic surgery | • Dental care (Adult) | • Infertility treatment |
| • Complications resulting from cosmetic surgery | • Habilitation services | • Long-term care |
| • Custodial care | • Hearing aids | • Non medically necessary surgery |
| | | • 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.)

- | | | |
|---------------------|--|----------------------------|
| • Acupuncture | • Non-emergency care when traveling outside the U.S. | • Private duty nursing |
| • Bariatric surgery | • Fertility Preservation | • Routine eye care (Adult) |
| • Chiropractic care | | • Routine foot care |

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: People First Service Center at 1-866-663-4735, 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. 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: your state insurance department at **1-877-693-5236**, The Division of State Group Insurance at 1-850-921-4600; Florida Blue at 1-800-825-2583;

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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 (Español): Para obtener asistencia en Español, llame al **1-800-352-8583**.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of [in-network](#) pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$250
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$2,400

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$2,970

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$250
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$700
Coinsurance	\$100

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,070

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$650

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) 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.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- 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)
- Provide 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:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (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 discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a [grievance](#) with:

Florida Blue (including FEP members)

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC1-7
Jacksonville, Florida 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
Section1557coordinator@floridablue.com

Florida Combined Life:

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

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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). FEP: 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 નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.
ફોન કરો [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: ફોન કરો [1-800-333-2227](tel: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.
با شماره 1-800-352-2583 تماس بگیرید. FEP: با 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.