# BlueChoice 0702 (Premium Plan)

Coverage Period: 08/01/2020 - 07/31/2021

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services **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 1-800-345-3885. For Rx information call RxEDO at 1-888-879-0168. 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: **$300** Per Person/**$900** Family. Out-of-Network: Not Applicable. | 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?** | Yes. **$300** Out-of-Network Per Admission Deductible; **$50** In-Network/ **$50** Out-of-Network Per ER Visit. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Yes. In-Network: **$2,500** Per Person/**$7,500** Family. Out-Of-Network: Combined with In-Network. | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-345-3885 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 + 30% Coinsurance | Physician administered drugs may have higher cost shares. |
| | Specialist visit | $50 Copay per Visit | Deductible + 30% Coinsurance | Physician administered drugs may have higher cost shares. |
| | Preventive care/screening/ immunization | No Charge | 30% 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: 10% Coinsurance/ Independent Diagnostic Testing Center: $50 Copay per Visit | Deductible + 30% Coinsurance | Tests performed in hospitals may have higher cost-share. |
| | Imaging (CT/PET scans, MRIs) | $50 Copay per Visit | Deductible + 30% Coinsurance | Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied. |
| | Generic drugs | Greater of $5 or 30% | Member pays full cost at purchase and must file a claim for reimbursement. | Quantity limits may apply. |

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

| 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 drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.rxedo.com | | Coinsurance to $50 Maximum, per Rx | | |
| | Preferred brand drugs | Greater of $30 or 30% Coinsurance to $50 Maximum, per Rx | Member pays full cost at purchase and must file a claim forreimbursement. | Quantity limits may apply. |
| | Non-preferred brand drugs | Greater of $45 or 30% Coinsurance to $50 Maximum, per Rx | Member pays full cost at purchase and must file a claim forreimbursement. | Prior authorization may be required. |
| | Specialty drugs | 10% Coinsurance to $225 Maximum per Rx out of Pocket Individual | Not Covered | Prior authorization may be required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible + 10% Coinsurance | Deductible + 30% Coinsurance | ————none———— |
| | Physician/surgeon fees | Ambulatory Surgical Center: $50 Copay per Visit/ Hospital: Deductible + 10% Coinsurance | Ambulatory Surgical Center: Deductible + 30% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance | ————none———— |
| **If you need immediate medical attention** | Emergency room care | Per Visit Deductible + Deductible + 10% Coinsurance | Per Visit Deductible + In-Network Deductible + 10% Coinsurance | ————none———— |
| | Emergency medical transportation | 10% Coinsurance | 10% Coinsurance | ————none———— |
| | Urgent care | $25 Copay per Visit | Deductible + $25 Copay per Visit | ————none———— |

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

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | Deductible + 10% Coinsurance | Per Admission Deductible + Deductible + 30% Coinsurance | Inpatient Rehab Services limited to 21 days. |
| | Physician/surgeon fees | Deductible + 10% Coinsurance | In-Network Deductible + 10% Coinsurance | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Physician Office: $50 Copay per Visit / Hospital: Deductible + 10% Coinsurance | Deductible + 30% Coinsurance | ————none———— |
| | Inpatient services | Deductible + 10% Coinsurance | Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 30% Coinsurance | Prior Authorization may be required. Your benefits/services may be denied. |
| **If you are pregnant** | Office visits | $50 Copay per Visit | Deductible + 30% Coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | Deductible + 10% Coinsurance | In-Network Deductible + 10% Coinsurance | ————none———— |
| | Childbirth/delivery facility services | Deductible + 10% Coinsurance | Per Admission Deductible + Deductible + 30% Coinsurance | ————none———— |
| **If you need help recovering or have other special health needs** | Home health care | Deductible + 10% Coinsurance | Deductible + 30% Coinsurance | Coverage limited to 30 visits. |
| | Rehabilitation services | Physician Office: $50 Copay per Visit/ Outpatient Rehab Center: Deductible + 10% Coinsurance | Deductible + 30% Coinsurance | Coverage limited to 75 visits for Outpatient Therapy and Spinal 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 + 10% Coinsurance | Deductible + 30% Coinsurance | Coverage limited to120 days. |

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

| 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) | |
| | Durable medical equipment | Deductible + 10% Coinsurance | Deductible + 30% Coinsurance | Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. |
| | Hospice services | No Charge | Deductible + 30% 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Generic drugs
- Habilitation services
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- 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:** 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/ebsa/healthreform 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. 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 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 1-800-345-3885. 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. 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/consumer_info_health.html .

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? [ Yes / No ]**

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.*

## 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 | $300 |
| Specialist Copayment | $50 |
| Hospital (facility) Coinsurance | 10% |
| Other Coinsurance | 10% |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$1,600** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist Copayment | $50 |
| Hospital (facility) Coinsurance | 10% |
| Other Coinsurance | 10% |

**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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $6,000 |
| **The total Joe would pay is** | **$6,410** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist Copayment | $50 |
| Hospital (facility) Coinsurance | 10% |
| Other Coinsurance | 10% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $400 |
| Copayments | $100 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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.

## 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, DCC 1-7
Jacksonville, FL 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)
civilrightscoordinator@fclife.com

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is o ffered 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.

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

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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

-ÑÞã åÇÊÝ ÇáÕã æÇáÈßã: 1( 3852-253-008-ãáíæÙÉ: ÅÐÇ ßäÊ ÊÊÍÏË ÇÐßÑ ÇááÛÉ¡ ÝÅä ÎÏãÇÊ ÇáãÓÇÚÏÉ ÇááÛæíÉ ÊÊæÇÝÑ áß ÈÇáãÌÇä. ÇÊÕá ÈÑÞã 1 .7222-333-008-ÈÑÞã 1 ÇÊÕá .0778-559-008

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.

**સચન◌ા: જ◌ો તમ◌ે ગ◌ુજર◌ાત◌ી બ◌ોલત◌ા હ◌ો, ત◌ો ન◌ા:શ◌ુલ◌ ક ભ◌াષ◌ા સહ◌ાય સ◌ેવ◌ા તમ◌ાર◌ા м◌াટ◌ે ઉપલબ◌્ધ છ◌ે.**

**ફ◌ોન કર◌ો** 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફ◌ોન કર◌ો** 1-800-333-2227

ประกาศ:ถ◌้าค◌ุณพ◌ูดภาษาไทยค◌ุณสามารถใช◌้บริการช◌่วยเหลือทางภาษาได◌้ฟรี โดยต◌ิดต◌่อหมายเลขโทรฟรี **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 می‌کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
.ÏىÑىÊãÇÓ È 1-800-333-2227 ÈÇ ÔãÇÑå :FEP .ÏىÑىÊãÇÓ È 1-800-352-2583 (TTY: 1-800-955-8770) ÈÇ ÔãÇÑå

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

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