NORTH BAY HAVEN
BUCCANEERS

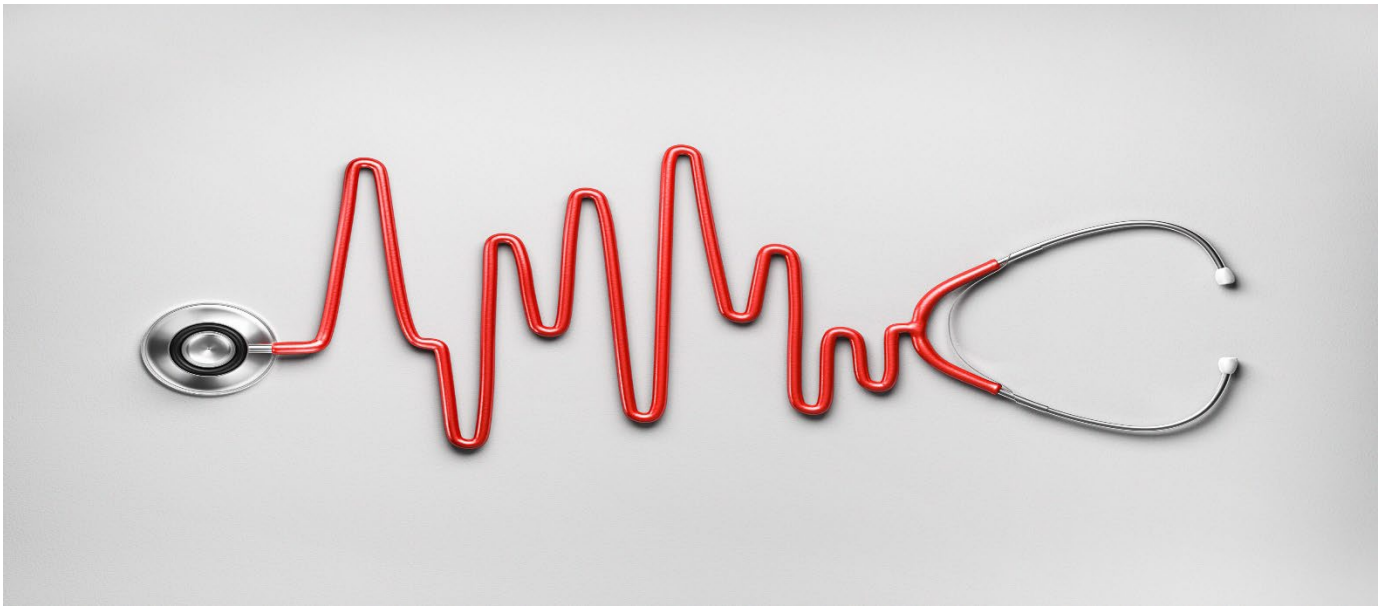
BAY HAVEN

Your Employee Benefits

Effective September 1, 2024 - August 31, 2025

CLEMONS COMPANY
Employee Benefits Group

IN THIS GUIDE



Eligibility & Enrollment

Eligibility

All full-time employees working at least 30 hours per week are eligible for benefits. As a new hire, all benefits begin on the first of the month following 30 days of continuous employment. Additionally, you may enroll in benefits during the annual Open Enrollment period each year for a September 1st effective date.

You may enroll the following eligible dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted or stepchildren up to age 26
- Unmarried children of any age if disabled & claimed as a dependent on your federal income taxes

Open Enrollment

Remember, other than a qualified life event you may only make changes to your benefit elections annually during the open enrollment period. The following are examples of Qualified Life Events:

- Change in marital status or number of dependents
- Dependent's employers open enrollment
- Entitlement to Medicare or Medicaid
- Dependent satisfies or ceased to satisfy eligibility requirements

Important State and Federal Notice

These notices, along with the Summary Plan Descriptions (SPD), and Summary of Benefits and Coverages (SBC) can be found through the online portal at www.employeenavigator.com

- HIPPA Notice of Special Enrollment
- Women's Health and Cancer Rights
- Privacy Practice and Rights under HIPAA
- General COBRA Notice of Rights
- CHIPRA Notice
- Medicare Part D Creditable Coverage Notice

Employee Navigator, your online enrollment portal

With online enrollment services powered by Employee Navigator, you enjoy convenient online access to your benefits coverage 24 hours a day, 7 days a week. On this site you will be able to make benefit elections, change personal information and access important documents.

https://employeenavigator.com/benefits/account/login
Your company identifier is: Bay Haven

How Do I Enroll?

Open Enrollment

You must enroll online in the benefit portal. Click "*Reset a forgotten password"* if needed to get started!

1) Review your current benefits
2) Enroll, waive, or make changes for the plan year
3) Review and update your dependent and beneficiary information

Newly Hired/Eligible Employees

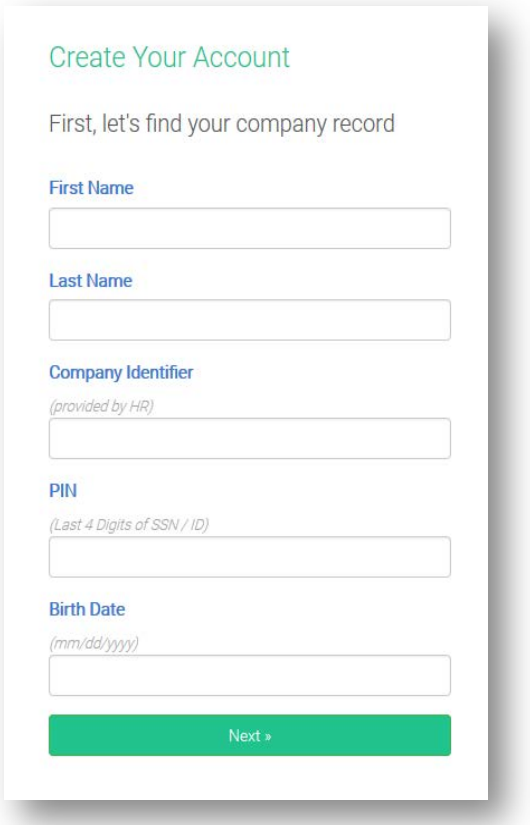
New hires and newly eligible employees must complete an initial enrollment even if you will waive coverage. You will be asked to provide a beneficiary for life insurance when you enroll.

Have social security numbers and birth dates for all dependents and beneficiaries before logging in.

Enrolling in Benefits:
Please review your Benefit Guide to gain an understanding of the plans being offered. After you have registered you may return at any time to access important resources and your summary of benefits.

Benefit Portal: www.employeenavigator.com
First Time User: Select Register as a new user
Enter the following:

- **First Name**
- **Last Name**
- **Company Identifier:** Bay Haven
- **Social Security Number** (last 4 digits)
- **Birth Date** (ex. 01/01/1900)



Health Insurance through Florida Blue / BCBS of Florida

Bay Haven Charter Academy employees have the option of enrolling in one of five medical plans. The medical plans are PPO (preferred provider organization) plans with in and out of network benefits. When looking for a doctor/facility go to www.bcbsfl.com and search for Blue Options providers.

Please refer to your Summary of Benefits and Coverages for more detailed information (available on Employee Navigator) or request copies from your HR Department.

The **in network benefits** are listed below:

	BO Plan 05908	BO Plan 03900	BO Plan 05772	BO Plan 05770
Annual Deductible	$5,000 / $10,000	$1,500	$2,000/$6,000	$1,000 /$3,000
Annual Out of Pocket Maximum (Med & RX)	$8,200 / $16,400	$6,350/$12,700	$5,500/$11,000	$3,500 / $7,000
In Network Coinsurance	20%	50%	20%	20%
Referrals Required	No	No	No	No
Physician Office Visits: PCP/Specialist	$0 Copay Visits 1-3 then $30 Copay/ $60 Copay	$35 Copay/ $50 Copay	$35 Copay / $65 Copay	$25 Copay / $45 Copay
Preventative Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Inpatient Hospital Care	Option #1- 20% after CYD Option #2- 20% after CYD	Option#1-$1,500 Copay / Option#2- $2,500 Copay	Opt #1 & Opt #2 - $100 PAD + 20% after CYD	Opt #1 & Opt #2 - 20% after CYD
Outpatient Surgery: ASC / Hospital	20% after CYD / Opt 1 & Opt 2: 20% after CYD	50% after CYD / Opt 1: $300 Copay / Opt 2: $400 Copay	$250 Copay / 20% after CYD	$150 Copay / Opt 1 & Opt 2 - 20% after CYD
Diagnostic: Lab @ Quest, X-Ray, Advanced Services	$0 Copay / $60 Copay / 20% after CYD	$0 Copay / 50% after CYD / $200 Copay	$0 Copay / $50 Copay / $300 Copay	$0 Copay/ $50 Copay/ $200 Copay
Emergency Room	$350 Copay	50% after CYD	$300 Copay	$200 Copay
Urgent Care	$100 Copay	50% after CYD	$70 Copay	$50 Copay
Mental Health: Office Visit/In Patient	$0 Copay / $0 Copay	$0 Copay / $0 Copay	$0 Copay / $0 Copay	$0 Copay / $0 Copay
Retail Prescription Drugs: Tier 1/ Tier 2 / Tier 3	$10 Copay / 20% Coins (limited brand) / NA	$10 Copay / 20% Coins (limited brand) / NA	$10 Copay / $60 Copay / NA	$10 Copay / $30 Copay / $50 Copay
Mail Order Prescriptions: Tier 1 / Tier 2 / Tier 3	$25 Generic Only / NA /NA	$25 Generic Only/ N/A / N/A	$25 Copay / $150 Copay / NA	$25 Copay / $75 Copay / $125 Copay
Specialty Drugs	Subject to Cost Share Based on Applicable Drug Tier	Subject to Cost Share Based on Applicable Drug Tier	Subject to Cost Share Based on Applicable Drug Tier	Subject to Cost Share Based on Applicable Drug Tier

Prices Per Month

Employee Only	$84.62	$124.70	$274.26	$420.13
Employee/Spouse	$832.92	$924.33	$1,265.33	$1,597.90
Employee/Child	$669.24	$749.41	$1,048.54	$1,340.26
Family	$1,370.76	$1,499.04	$1,977.65	$2,444.43

Health Insurance through Florida Blue / BCBS of Florida (cont.)

The in network benefits are listed below:

	BO HSA Plan 03160	BO HSA Plan 03161
Annual Deductible	$1,500	$3,000 per person / $30,00 per family
Annual Out of Pocket Maximum (Med & RX)	$5,000	$5,000 per person / $5,000 per family
In Network Coinsurance	20%	20%
Referrals Required	No	No
Physician Office Visits: PCP/Specialist	20% after CYD / 20% after CYD	20 % after CYD / 20% after CYD
Preventative Services	$0 Copay, Deductible Waived	$0 Copay, Deductible Waived
Inpatient Hospital Care	Option 1 & Option 2: 20% after CYD	Option 1 & Option 2: 20% after CYD
Outpatient Surgery: ASC / Hospital	20% after CYD / 20% after CYD	20% after CYD / 20% after CYD
Diagnostic: Lab @ Quest, X-Ray, Advanced Services	20% after CYD / 20% after CYD / 20% after CYD	20% after CYD / 20% after CYD 20% after CYD
Emergency Room	20% after CYD	20% after CYD
Urgent Care	20% after CYD	20% after CYD
Mental Health: Office Visit/In Patient	20% after CYD / 20% after CYD	20% after CYD
Retail Prescription Drugs: Tier 1/Tier 2/Tier 3	CYD + $10/$50/$80	CYD + $10/$50/$80
Mail Order Prescriptions: Tier 1/Tier 2/Tier 3	CYD + $25/$125/$200	CYD + $25/$125/$200
Specialty Drugs	Subject to Cost Share Based on Applicable Drug Tier	Subject to Cost Share Based on Applicable Drug Tier

Prices Per Month

Employee Only	$290.52	NA
Employee/Spouse	NA	$1,302.42
Employee/Child	NA	$1,081.06
Family	NA	$2,029.69

Welcome to Florida Blue

Get off to a good start!

- Sign up for an account at FloridaBlue.com and download the Florida Blue mobile app. This will give you 24/7 access to benefit coverage, claims information, id cards and nearby doctors and hospitals.
- Call Care Consultants to show you how your benefits work, manage costs , help finds doctors and community services you need to get well @ 888-476-2227.
- Better You Strides, our personal online wellness program, creates a customer made plan based on your needs, goals and interests to help you meet your health goals.
- Blue 365, an exclusive national member discount program offers savings on gym memberships, vision care, hearing aids, weight management programs and more.
- Mental Health with Lucent Behavioral Health Program, is a mental health resource to access self help, screening tools, community resources, care management & Autism Resource Programs @ 866-287-9569.
- Use CareCentrix if you need special medical care or equipment. CareCentrix coordinates home health care, home infusions and specialized medical equipment called durable medical equipment. If you currently use or need to use these supplies or services, please call CareCentrix directly @ 866-776-4617.

- Save money on prescriptions. Know what is covered before you fill any prescriptions using your new plan, log in at FloridaBlue.com to check the list of covered medications.
  - Choose a pharmacy in the Preferred Pharmacy Network and pay a lower cost share.
  - Use home delivery for regular, non-specialty prescription refills.
    Amazon Pharmacy will deliver right to your door.
- Condition Care RX Program! Through the Condition Care RX Program, medicines to treat things like high blood pressure, cholesterol, diabetes, depression and respiratory conditions could cost little to next to nothing.

Lucet™

The Behavioral Health Optimization Company

The mental health care you deserve.

Lucet Behavioral Health Program

We know prioritizing your mental health is tough—and even tougher to find an available provider who's the right fit. That's why your Florida Blue health plan has partnered with Lucet to guide you to the right provider or behavioral health resources.

We're your partners in health.

- Understand your behavioral health needs and benefits.
- Locate in-network behavioral health providers, specialty doctors and treatment facilities.
- Connect with those in your community that can support your mental well-being journey.
- Coordinate care with your providers.

Connect to support

Visit LucetHealth.com/members/resource to access self-help and screening tools and find community resources for things like addiction, child abuse, employment, food pantries, military families and parenting.

You can reach us at 866-287-9569. Based on the unique needs of each member, you may be transferred to one of our specialty service teams below.

Specialty services

Care Management Program

Work with a licensed behavioral health clinician who can help you identify your needs, create a treatment plan and coordinate with your providers.

Autism Resource Program

Care managers specially trained in treating autism spectrum disorder can assist you through the process of obtaining a diagnosis and authorizing treatment.

Substance Use Disorder Clinical Response Unit

Licensed clinicians can assess your needs, share information about evidence-based treatment options and assist you through the process of obtaining care.

Lucet supports treatment for:

- Depression
- Anxiety
- Substance Use Disorder
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Schizophrenia

✦ Optimize access across your behavioral health ecosystem

Contact us at 866-287-9569 to learn more.

LucetHealth.com

Florida Blue

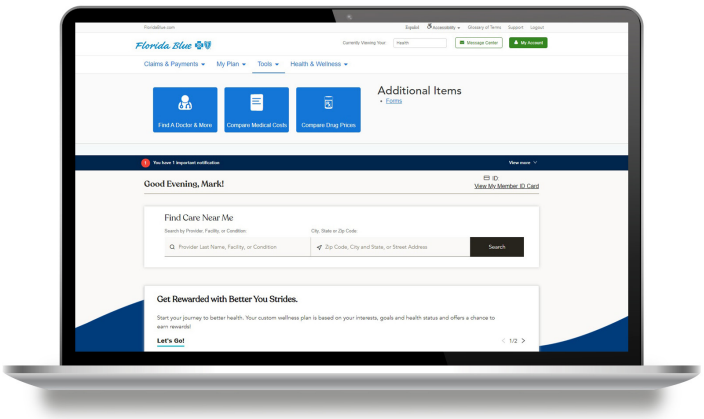
Need Care and Don't Know Where to Go?

No matter where you are, a doctor, urgent care center, or hospital is right at your fingertips.

Online

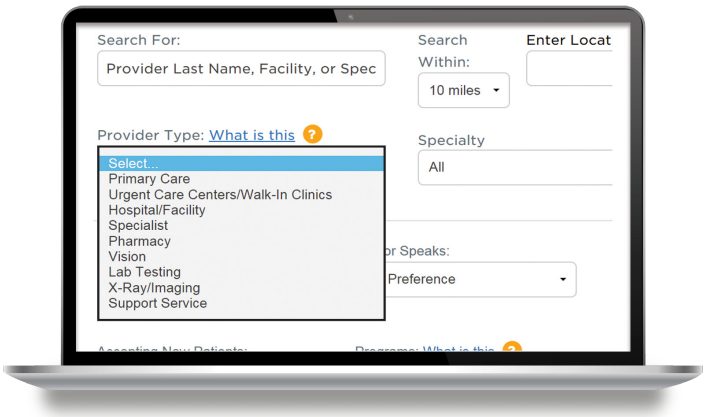
Step 1. Log in to **floridablue.com**.

Step 2. At the top of the screen, click **Tools** and select **Find A Doctor & More**.

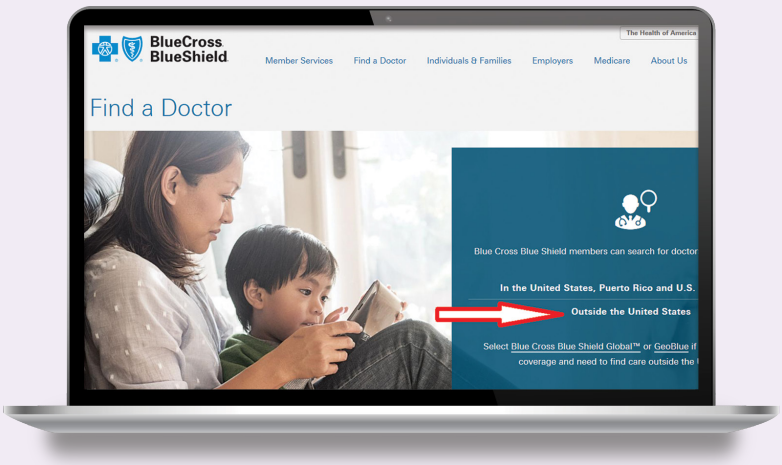


Step 3. In the search form, simply enter the provider's last name, facility, specialty, condition or NPI. You can also click the **Provider Type** dropdown and choose between:

- Primary Care
- Urgent Care Centers
- Hospitals and more



Step 4. Click the **Search Now** button. For virtual visits covered at $0, look for the **Virtual Visit** banner and click **Get Started**.



Outside Florida? Find Care From Anywhere!

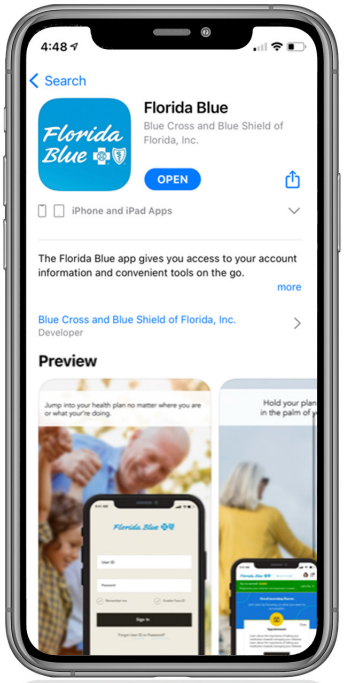
You're always covered for urgent and emergency care outside of Florida. Some plans have additional out-of-state benefits.*

1. Log in to **bcbs.com/find-a-doctor** or call **800-810-2583**.
2. Click on **In the United States**.
3. Enter a **Location** and **Plan** to find care anywhere in the U.S.

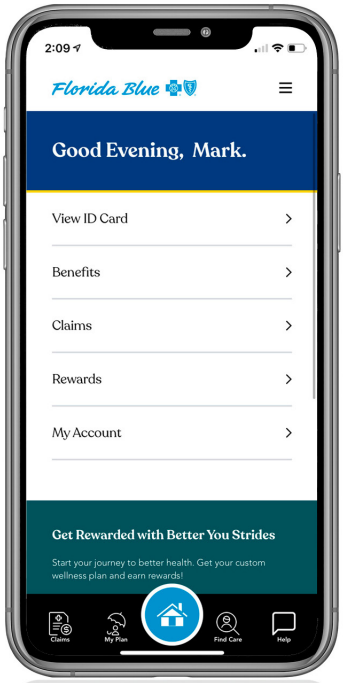
103723 1020 IU65 | SG

CLEMONS COMPANY
Employee Benefits Group

On Your Mobile Device

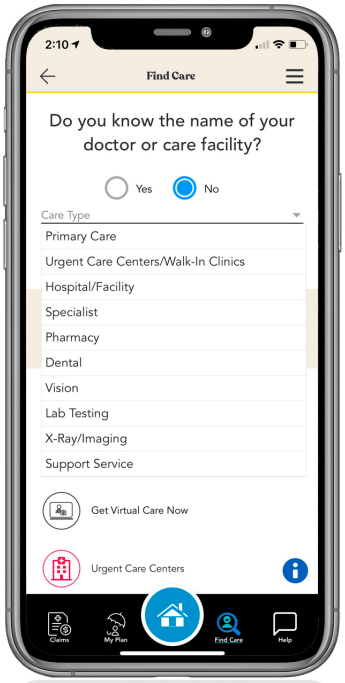


Step 1. Download the **Florida Blue mobile app** from the iTunes or Google Play app store.



Step 2. Open the app and log in to reach your member dashboard. On the navigation bar at the bottom of the screen, click **Find Care**.

Step 3. At the **Find Care** screen, click **Florida Doctors** and **Pharmacies**.

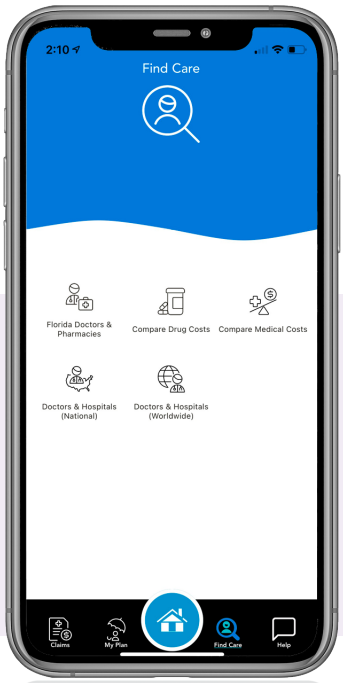


Step 4. Select **Yes** and search by entering the provider's last name, facility, specialty, condition or NPI.

Select **No**, then click the **Care Type** dropdown button and choose between primary care, urgent care centers, hospitals and more.

Step 5. Click **Get Results**.

For virtual visits, click **Get Virtual Care Now** and **Get Started!**



Outside Florida? Find Care From Anywhere!

You're always covered for urgent and emergency care outside of Florida. Some plans have additional out-of-state benefits.*

1. Open the app and login. Click **Find Care** on the navigation menu.
2. Click on **Doctors & Hospitals (National)**.
3. Choose a **Location** and **Plan** to find care anywhere in the U.S.

*Please refer to your policy for information on the specific cost shares applicable to this service outside of Florida, or call the telephone number on the back of your member ID card.

Teladoc is included for employees in the medical plan. If not enrolled in medical employees can purchase Teladoc for $6.95 per month.

REGISTER WITH TELADOC TODAY!

Once registered, you can speak with a licensed doctor within minutes. **Anytime. Anywhere.**

3 WAYS TO REGISTER

Online OR **Mobile App** OR **Phone**

During registration, you'll complete your medical history so when you need Teladoc®, it'll be fast and easy.

Teladoc is the easy, convenient, and affordable option for quality medical care. Our licensed doctors can treat cold and flu symptoms, respiratory infections, sinus problems, and more!

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for **free!**

Teladoc.com

1-800-Teladoc

Facebook.com/Teladoc

Teladoc.com/mobile

10E-179
0116

Policyholder: BAY HAVEN CHARTER ACADEMY INC

Group dental insurance
Benefit summary for
Dental Low Plan

Your coverage renews every September 1

Dental Low Plan Cost Per Month:

EE Only	$8.46
EE/Spouse	$42.73
EE/Child	$57.85
Family	$104.03

What's available to me?

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your in-network deductiblesfor basic and major services are combined. Your out-of-network deductibles for basic and major are combined. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Combined maximum	Your calendar year year maximum for preventive, basic, and major in-network services are combined. Your calendar year year maximum for preventive, basic, and major out-of-network services are combined. In-network calendar year year maximums are $1,000 per person or out-of-network calendar year year maximums are $1,000 per person. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Maximum accumulation	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Twice per calendar year
Full mouth X-rays	Once every 36 months
Fluoride	Once per calendar year (covered only for dependent children under age 19)
Sealants	Covered only for dependent children under age 19; once per tooth each 36 months
Harmful habit appliance	Covered only for dependent children under age 19

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Major	
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth

Non-surgical periodontics	Once per quadrant per 24 months (including scaling and root planing)
Periodontal surgical procedures	Once per quadrant per 36 months
Crowns	Each 60 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 60 months per tooth
Bridges	60 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

Policyholder: BAY HAVEN CHARTER ACADEMY INC

Group dental insurance
Benefit summary for
Dental High Plan

Your coverage renews every September 1

What's available to me?

Dental High Plan Cost Per Month:

EE Only	$19.63
EE/Spouse	$58.13
EE/Child	$72.90
Family	$126.05

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%
Orthodontia	$0	$0	50%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your in-network deductiblesfor basic and major services are combined. Your out-of-network deductibles for basic and major are combined. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Combined maximum	Your calendar year year maximum for preventive, basic, and major in-network services are combined. Your calendar year year maximum for preventive, basic, and major out-of-network services are combined. In-network calendar year year maximums are $1,500 per person or out-of-network calendar year year maximums are $1,500 per person. Your services applied to the in-network deductible will apply to the out-of-network deductible and vice versa.			
Orthodontia lifetime maximum	$1,000 PPO in-network maximum / $1,000 PPO out-of-network maximum			
Maximum accumulation	Included			
Plan type	Unscheduled			

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Twice per calendar year
Full mouth X-rays	Once every 36 months
Fluoride	Once per calendar year (covered only for dependent children under age 19)
Sealants	Covered only for dependent children under age 19; once per tooth each 36 months
Harmful habit appliance	Covered only for dependent children under age 19

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Composite (tooth colored)	Covered on posterior teeth
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months

Periodontal surgical procedures	Once per quadrant per 36 months
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Major	
Crowns	Each 60 months per tooth if tooth cannot be restored by a filling. Porcelain crowns covered on posterior teeth
Core buildup	Each 60 months per tooth
Implants	Each 60 months per tooth
Bridges	60 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)

Orthodontia	
Coverage	For you and your dependents.

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 95th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.

Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.
General anesthesia program	If you have autism, Down syndrome, cerebral palsy, muscular dystrophy, or spina bifida you may receive general anesthesia or intravenous sedation coverage. Services must be administered in a dental office. All other contractual limitations apply.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth provision –This means the initial placement of bridges, partials, dentures, and implant services to replace teeth missing before this coverage starts may not be covered. If the policy your employer purchased replaces coverage with another carrier, continuous coverage under the prior plan may be applied and you may be eligible for coverage to replace teeth missing before this coverage started. Your effective date with your current employer, along with the employer's effective date with Principal are used to determine coverage. MIssing tooth provision doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information. We strongly recommend submitting a predetermination to determine benefits.

What are the restrictions of my coverage?

Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

There are additional limitations to your coverage. A complete list is included in your booklet.

Policyholder: BAY HAVEN CHARTER ACADEMY INC

Group voluntary vision

Benefit summary for all members

Your coverage renews every September 1

Vision Cost Per Month:

EE Only	$7.20
EE/Spouse	$15.00
EE/Child	$14.00
Family	$20.99

What's available to me?

Vision insurance is offered through Principal® and VSP® Vision Care. It provides choice, flexibility and savings through a VSP doctor.

If you buy this coverage, an established network of VSP doctors will provide quality care for you and your dependents.

VSP choice network	
Exams	Every 12 months, one exam is covered in full after $10 copay
Prescription glasses Lenses - 1 pair covered every 12 months Frames - covered up to $130 every 24 months; 20% off amount over allowance[1]	$10 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses • Polycarbonate lenses for dependent children under age 18
Lens enhancements	Standard progressive lenses covered once every 12 months with a $0 copay[1] Most other popular lens enhancements are covered after a copay, saving our members an average of 30%[1]
Elective contacts	Covered up to $130 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evaluation	Up to $60 copay
Necessary contacts	Covered in full after $10 copay every 12 months Contact lenses can be chosen instead of glasses.

[1]This can vary based on state laws and provider location Savings may not apply at participating retail chains.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees can't purchase.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period.
- If you're covered, you may buy coverage for your dependents.

Additional eligibility requirements may apply.

What's the difference between elective and necessary contacts?

- Elective - when vision can be corrected by glasses, but contacts are worn.
- Necessary - when vision can't be corrected with glasses due to extreme vision problems.

Why am I charged an additional copay for contact fitting and evaluation?

- Contact lens wearers require an additional evaluation of the eyes' measurements, and possible follow-up appointments, for fitting and training on proper use of contact lenses.
- For these additional services, you won't pay more than $60 at in-network providers.

Are benefits the same for all VSP doctors?

- Yes, with the exception of Costco®, Walmart®, and Sam's Club®. The frame allowance at these locations is $70 which is equivalent to a $130 allowance at other VSP doctor locations. Not all providers at participating retail chains are in-network for exam services.
- Benefits may also vary by location due to state law.

How do I find a VSP doctor?

- Visit vsp.com to locate VSP doctors close to you -- or to see if your current eye care professional is in the VSP network.
  - You'll need to choose the "Choice" doctor network to view the VSP doctors for your coverage.
- Call 800-877-7195.

Will I get an ID card?

- Yes, your card will have a unique member ID that your doctor will use to verify benefits.

Will my doctor submit my claim?

- If you're seeing a VSP doctor, they'll submit the claim for you.
- If you're seeing someone outside the VSP network, you're responsible for submitting your own claim. You can get that form from vsp.com after logging in as a member using your member ID. Or call 800-877-7195.

Are there any additional savings with VSP?

- Glasses and sunglasses - you can save an average of 20-25% off glasses or sunglasses from any VSP doctor within 12 months of your last covered vision exam.
- Laser vision correction - you pay an average of 15% off the regular price and 5% off the promotional price. You'll only receive these discounts from contracted clinics. Go to VSP.com and register using your member ID to see the laser vision promotions and find a contracted clinic.

These savings can vary based on state laws and provider location.

What benefits do I receive if my doctor is outside VSP's network?

Covered charges	Benefit	Frequency
Exams	Up to $45	Once every 12 months
Single lenses	Up to $30	One pair every 12 months
Lined bifocal lenses	Up to $50	One pair every 12 months
Lined trifocal lenses	Up to $65	One pair every 12 months
Lenticular lenses	Up to $100	One pair every 12 months
Frames	Up to $70	One set every 24 months
Elective contacts	Up to $105	Contacts are instead of frames and lenses
Necessary contacts	Up to $210	Contacts are instead of frames and lenses

What are the limitations of my benefits?

- Visual analysis or vision aids that aren't medically necessary aren't covered.
- No benefits will be paid for:
  - Non-prescription glasses
  - Medical or surgical treatment of the eyes
  - Claims submitted by a doctor who is part of your family

Once enrolled, you'll receive a booklet with more details regarding your plan limitations and exclusions.

Standard Insurance Company
Bay Haven Charter Academy
Group Policy #172906
Effective Date September 1, 2024

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Bay Haven Charter Academy.

Eligibility

Definition of a Member	You are a member if you are a regular employee of Bay Haven Charter Academy and actively working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 30 consecutive days as a member.

Benefits

Basic Life Coverage Amount	1 times your annual earnings to a maximum of $125,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65, to 40 percent at age 70 and to 20 percent at age 75.

Other Basic Life Features and Services

- Accelerated Death Benefit
- Employee Assistance Program
- Life Services Toolkit
- Portability of Insurance
- Repatriation Benefit
- Right to Convert
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Family Benefits Package
- Helmet Benefit
- Seat Belt and Air Bag Benefits

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Bay Haven Charter Academy. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Bay Haven Charter Academy may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 22165-D-FL-172906 (7/24)
7629926-1187313

Standard Insurance Company
Bay Haven Charter Academy
Group Policy #172906

Group Additional Life and AD&D Insurance

Help protect your loved ones from financial hardship.

Life insurance coverage is designed to help provide financial support and stability to your family should you pass away. Accidental Death & Dismemberment (AD&D) insurance provides an extra layer of protection if you die or become dismembered in an accident. You can also cover your eligible spouse and child(ren).

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you are dismembered, become terminally ill or die

About This Coverage

If you take no action you'll be covered under Basic Life insurance provided you meet the eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund your children's education. If not, you may want to apply for additional coverage now.

Life Insurance		
How Much Can I Apply For? Your combined Basic Life and Additional Life amounts cannot exceed a maximum of 8 times your annual earnings. The coverage amount for your spouse cannot exceed 100 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 100 percent of your Additional Life coverage.	For You:	**$10,000** – **$300,000** in increments of **$10,000**
	For Your Spouse:	**$5,000** – **$100,000** in increments of **$5,000**
	For Your Child(ren):	**$5,000** or **$10,000**
What is the Guarantee Issue Maximum? Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions. To apply for an amount over the guarantee issue, visit **https://myeoi.standard.com/172906** to complete and submit a medical history statement online.	For You:	Up to **$150,000**
	For Your Spouse:	Up to **$30,000**

AD&D Insurance The benefit is paid if you or your dependents are seriously injured or pass away as a result of a covered accident.		
What Does My AD&D Benefit Provide? Note: You cannot buy more coverage for your spouse or child(ren) than you buy for yourself.	For You:	The AD&D insurance coverage amount matches what you elect for Additional Life insurance.
	For Your Spouse:	The AD&D insurance coverage amount matches what you elect for Dependent Life insurance.
	For Your Child(ren):	The AD&D insurance coverage amount matches what you elect for Dependent Life insurance.
Keep in mind that the amount payable for certain losses is less than 100 percent of the AD&D insurance benefit.		

See the Important Details section for more information, including requirements, exclusions, limitations, age reductions and definitions.

Additional Feature

Life Insurance	
Accelerated Death Benefit	If you become terminally ill, you may be eligible to receive up to 80 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How Much Life Insurance Do You Need?

After a serious accident or death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs**.

How Much Your Coverage Costs

Your Basic Life insurance is paid for by Bay Haven Charter Academy. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

_____	÷ 1000 =	_____	x	_____	=	_____	→	_____
Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).				Enter your rate from the rate table.		This amount is an estimate of how much you would pay each month.		To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate.

If you buy Dependent Life with AD&D coverage for your child(ren), your monthly rate is $0.22 per $1,000, no matter how many children you're covering. Your monthly AD&D rate of $0.02 per $1,000 is included.

Age (as of September 1)	Your Rate* (Per $1,000 of Total Coverage)	Your Spouse's Rate** (Per $1,000 of Total Coverage)
<25	$0.097	$0.097
25–29	$0.090	$0.090
30–34	$0.123	$0.123
35–39	$0.149	$0.149
40–44	$0.227	$0.227
45–49	$0.279	$0.279
50–54	$0.813	$0.813
55–59	$0.955	$0.955
60–64	$1.345	$1.345
65–69	$2.203	$2.203
70+	$3.815	$3.815

*Includes a monthly AD&D rate of $0.02 per $1,000 of AD&D benefit.
**Includes a monthly AD&D rate of $0.02 per $1,000 of AD&D benefit for your spouse.

Important Details

Here's where you'll find the details about the plan.

Life and AD&D Insurance Eligibility Requirements

A minimum number of eligible employees must apply and qualify for the proposed plan before coverage can become effective. If this requirement is not met, this plan will not become effective. To be eligible for coverage, you must be:

- Insured for Basic Life insurance through The Standard
- A regular employee of Bay Haven Charter Academy
- Actively working at least 30 hours per week

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life and AD&D insurance for yourself, you may also buy Life and AD&D coverage for your eligible children and/or spouse. This is called Dependent Life and AD&D insurance.

You can choose to cover your spouse, meaning a person to whom you are legally married, or your domestic partner as recognized by law.

You may also choose to cover your child. Child means your child from live birth through age 25. Please note:

- Your child cannot be insured by more than one employee.
- Your spouse and/or child(ren) must not be full-time member(s) of the armed forces.
- You cannot be insured as both an individual and a spouse.

Medical Underwriting Approval for Life Coverage

Required for:

- Coverage amounts higher than the guarantee issue maximum amount
- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements, if required
- Eligible but not insured under the prior life insurance plan

Visit **https://myeoi.standard.com/172906** to complete and submit a medical history statement online.

Coverage Effective Date for Life Coverage

To become insured, you must:

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Receive medical underwriting approval (if applicable),
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance, including any Dependent Life insurance, will not become effective until the day after you complete one full day of active work as an eligible employee.

You may have a different effective date for Life coverage below and above the guarantee issue amount.

If your dependent is confined to a hospital or nursing home on the scheduled effective date of your dependent's insurance, your dependent's insurance will not become effective until the day the dependent is released.

Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your insurance, including any Dependent Life insurance.

*Defined as first of the month that follows 30 consecutive days as a member

Life and AD&D Age Reductions

Under this plan, your coverage amount reduces to 65 percent at age 65, to 40 percent at age 70 and to 20 percent at age 75. Your spouse's coverage amount reduces by your age as follows: to 65 percent at age 65, to 40 percent at age 70 and to 20 percent at age 75. If you are age 65 or over, ask your Human Resources representative or plan administrator for the amount of coverage available.

Life Insurance Waiver of Premium

Your Life premiums may be waived if you:

- Become totally disabled while insured under this plan,
- Are under age 60, and
- Complete a waiting period of 180 days.

If these conditions are met, your Life insurance coverage may continue without cost until Social Security Normal Retirement Age (SSNRA), provided you give us satisfactory proof that you remain totally disabled. Please contact your benefits administer for more details.

Life and AD&D Insurance Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Life Insurance Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Life Insurance Exclusions

Subject to state variations, you and your spouse are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

AD&D Benefits

The amount of the AD&D benefit is equal to the amount payable for your or your spouse's or child(ren)'s Life benefit on the date of the accident. For all other covered losses, the amount is shown as a percentage of the amount payable for the benefit on the date of the accident. No more than 100 percent of the AD&D benefit will be paid for all losses resulting from one accident.

Any loss must be caused solely and directly by an accident within 365 days of the accident. Satisfactory proof of loss is required for loss of life.

All other losses must be certified by a physician in the appropriate specialty determined by The Standard.

Covered loss:	Percentage of AD&D benefit payable:
Life[1]	100%
One hand or one foot[2]	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%
Quadriplegia	100%
Triplegia	75%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

1 Includes loss of life caused by accidental exposure to adverse weather conditions or disappearance if disappearance is caused by an accident that reasonably could have resulted in your death.

2 Even if the severed part is surgically re-attached. If you lose a hand or foot and an AD&D benefit is payable for quadriplegia, triplegia, paraplegia, hemiplegia, or uniplegia, involving that same hand or foot, the benefit will be the higher of the AD&D benefit for that loss.

3 This benefit is not payable if an AD&D benefit is payable for the loss of the entire hand.

AD&D Insurance Exclusions

You are not covered for death or dismemberment caused or contributed to by any of the following:

- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Suicide or other intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared), and any substantial armed conflict between organized forces of a military nature
- Voluntary consumption of any poison, fumes or drug, unless used or consumed according to the directions of a physician
- Alcohol – if your blood alcohol content is in excess of the legal limit for operating a motor vehicle as defined by the jurisdiction where the accident or loss occurred
- Sickness, pregnancy, heart attack or stroke existing at the time of the accident
- Medical or surgical treatment for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy
- The date your Life coverage ends, your AD&D coverage will end as well

In addition to the above requirements, your Dependent Life and AD&D coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Standard Insurance Company
Bay Haven Charter Academy
Group Policy #172906
Effective Date September 1, 2024

Group Short Term Disability Insurance

Group Short Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this insurance is paid by Bay Haven Charter Academy.

Eligibility

Definition of a Member	You are a member if you are an active employee of Bay Haven Charter Academy, and regularly working at least 30 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 30 consecutive days as a member.

Benefits

Weekly Benefit	60 percent of the first $417 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$250
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable after you have been continuously disabled for 7 days for disability caused by accidental injury and after 7 days for disability caused by physical disease, pregnancy or mental disorder.
Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, or • You are unable to earn more than 60 percent of your predisability earnings when you work for your employer.
Maximum Benefit Period	90 days

Other Features and Services

- Temporary Recovery Provision

This information is only a brief description of the group Short Term Disability insurance policy sponsored by Bay Haven Charter Academy. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Bay Haven Charter Academy may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13277-D-FL-172906 (7/24)
7629926-1187314

Standard Insurance Company
Bay Haven Charter Academy
Group Policy #172906

Group Long Term Disability Insurance

Protect your income when you're coping with a long-lasting disability.

This coverage is designed to replace a portion of your income when you're disabled for an extended period of time due to a qualifying disability and help you get back to work when you're ready. Long Term Disability insurance benefits can help you pay your bills and safeguard your savings when you're unable to work. Whether you're out for a few months or several years, this benefit can help you protect your income — and those who depend on it.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for a qualifying disability that occurs on or off the job

About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

What Your Benefit Provides This is the amount per month you would receive if you were to suffer a qualifying disability. Eligible earnings are your monthly insured predisability earnings, as defined by the group policy. Your monthly benefit will be reduced by deductible income. Please see the Important Details section for a list of deductible income sources.	**60%** of your eligible earnings, up to a maximum benefit of **$6,000** per month. Plan minimum per month: **$100**.
Benefit Waiting Period If you experience a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you become eligible to receive your monthly benefit	90 days
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive disability benefits for a continuous disability.	Until your Social Security Normal Retirement Age (SSNRA) Depending on your age at the time of disability, your benefits may be subject to a different schedule. Refer to the "Maximum Benefit Period" table in the Important Details section for specifics.

Additional Features

Your coverage comes with some added features:

Help with Returning to Work	This plan provides incentives to help you get back to work. For instance, you'll get help paying for some of the expenses associated with participating in an approved rehabilitation plan. If a worksite modification would enable you to return to work, the coverage can help your employer make approved modifications. You may also be eligible to receive an additional benefit of 10 percent of your predisability earnings for participating in an approved rehabilitation plan, subject to the plan maximum.
Survivors Benefit	If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment.

How Much Your Coverage Costs

Because this insurance is offered through Bay Haven Charter Academy, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and benefit amount.

Use this formula to calculate your premium payment:

_____	x	_____	÷ 100 =	_____	→	_____
Enter your monthly earnings (cannot be more than $10,000).		Enter your rate from the rate table.		This amount is an estimate of how much you'd pay each month.		To get a sense of your semimonthly premium, divide your monthly premium amount by 2.

Your Age (as of September 1)	Rate %
<25	0.06
25–29	0.09
30–34	0.16
35–39	0.26
40–44	0.45
45–49	0.59
50–54	0.84
55–59	0.83
60–64	0.56
65–69	0.41
70+	1.08

As you consider Long Term Disability insurance, evaluate what makes sense for you.

Getting by without a paycheck isn't easy, especially for an extended period of time. Make sure you have enough financial protection to help you cover your housing costs, utilities and other bills.

To estimate your insurance needs, you'll need to consider your unique circumstances.
Use our online calculator at **www.standard.com/disability/needs**.

Important Details

Here's where you'll find the details about the plan.

Eligibility Requirements

A minimum number of eligible employees must apply and qualify for the proposed plan before the coverage can become effective. If this requirement is not met, this plan will not become effective. To be eligible for coverage, you must be:

- A regular employee of Bay Haven Charter Academy
- Actively working at least 30 hours per week
- A citizen or resident of the United States or Canada

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Employee Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed above
- Serve an eligibility waiting period*
- Apply for coverage and agree to pay premiums
- Be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior long term disability insurance plan are also subject to medical underwriting approval.

Visit **https://myeoi.standard.com/172906** to complete and submit a medical history statement online.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

*Defined as first of the month that follows 30 consecutive days as a member

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification

- A preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the exclusion period and you have been actively at work for at least one full day after the end of the exclusion period

Preexisting Condition Provision

A preexisting condition is a mental or physical condition whether or not diagnosed or misdiagnosed during the 90-day period just before your insurance becomes effective:

- For which you or a reasonably prudent person would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications
- Which, as a result of any medical examination, including routine examination, was discovered or suspected

Exclusion Period: 12 months

Limitations

Long Term Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your indexed predisability earnings, but you elect not to work. During the first 24 months after the end of the benefit waiting period, the responsibility to work is limited to work in your own occupation; thereafter, the responsibility to work includes work in any occupation.

In addition, the length of time you can receive Long Term Disability payments will be limited if:

- You reside outside of the United States or Canada
- Your disability is caused or contributed to by mental disorders, substance abuse or the environment, chronic fatigue conditions, chronic pain conditions, carpal tunnel or repetitive motion syndrome or temporomandibular joint disorder or craniomandibular joint disorder

When Your Benefits End

Your Long Term Disability benefits end automatically on the date any of the following occur:

- You are no longer disabled
- Your maximum benefit period ends
- Benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- You fail to provide proof of continued disability and entitlement to benefits
- You pass away

Deductible Income

Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving Long Term Disability benefits. Deductible income includes:

- Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts) paid to you by your employer that exceeds 100 percent of your indexed predisability earnings when added to your LTD benefit
- Benefits under any workers' compensation law or similar law
- Amounts under unemployment compensation law
- Social Security disability or retirement benefits, including benefits for your spouse and children
- Amounts because of your disability from any other group insurance
- Benefits under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you work as much as your disability allows
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone or through video.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

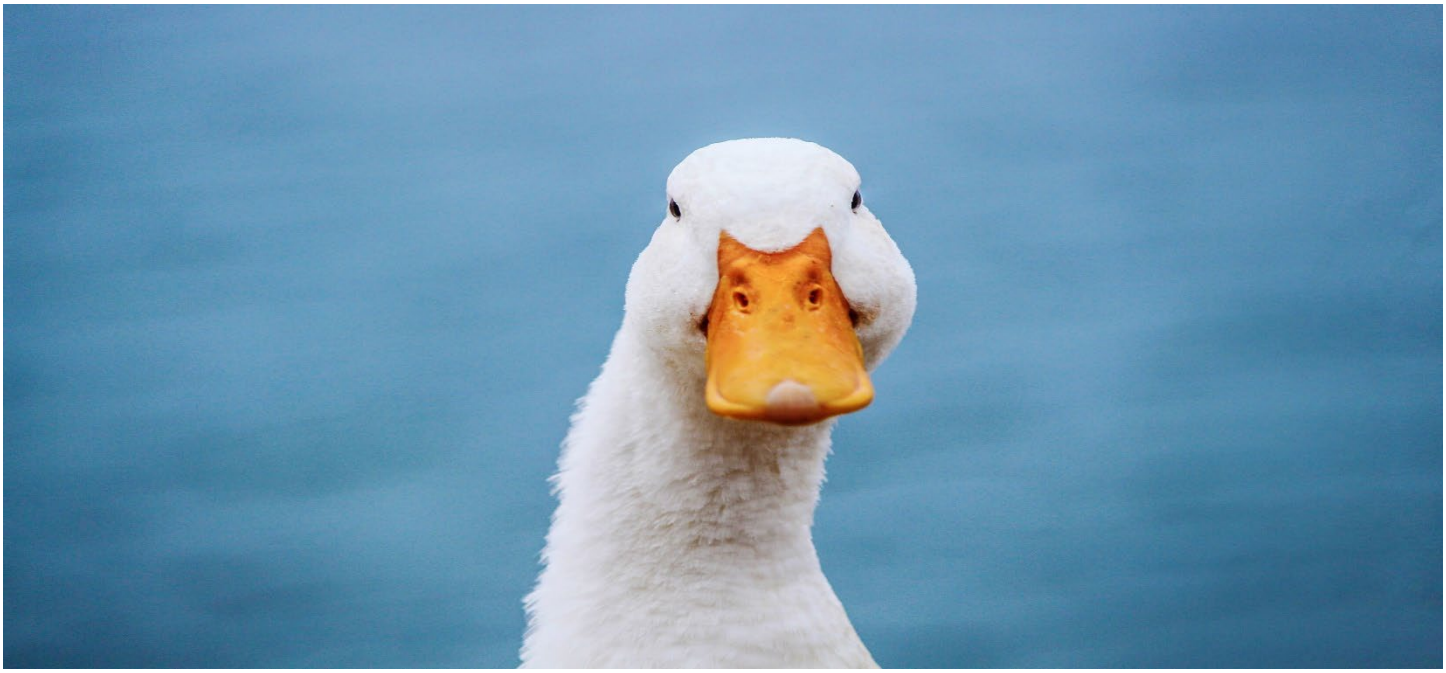
Supplemental Insurance

Your enrollment isn't complete until you have AFLAC!

Health Insurance wasn't designed to cover everything. That's why there is AFLAC. AFLAC can help you take care of what health insurance doesn't cover, so you and your family can focus on everything else in your life.

AFLAC supplemental benefits:

- Short Term Disability: how would you pay your bills if you are disabled and can't work? An AFLAC short term disability policy can help provide you with a source of income while you concentrate on getting well.
- Accident: Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits.
- Cancer/Specified Disease: AFLAC's cancer/specified disease insurance policy can help you and your family cope financially if a positive diagnosis of cancer occurs.
- Critical Illness: An AFLAC specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.
- Whole or Term Life Insurance: with AFLAC's whole or term life insurance you can rest easy knowing that your family can have financial security when they need it most.



To learn more scan the QR code or contact your AFLAC agent, Anna Thompson @ 919-649-8171 at a2thompson@us.aflac.com or schedule a meeting at https://a2thompson.youcanbook.me

Online Resources & Enrollment

	PHONE	WEB/EMAIL
AFLAC	919-649-8171	a2_thompson@us.aflac.com
BCBS/Florida Blue	866-946-2583	www.floridablue.com
Dental	800-986-3343	www.principal.com
Vision	800-986-3343	www.principal.com
Teladoc	800-835-2362	www.TeladocHealth.com
The Standard	888-937-4783	www.thestandard.com

Your Benefit Resources
More details about the benefits offered to you can be found by:

- Logging into Employee Navigator
- Registering on the insurance company websites
- Downloading the insurance company smartphone apps
- Calling the insurance company directly

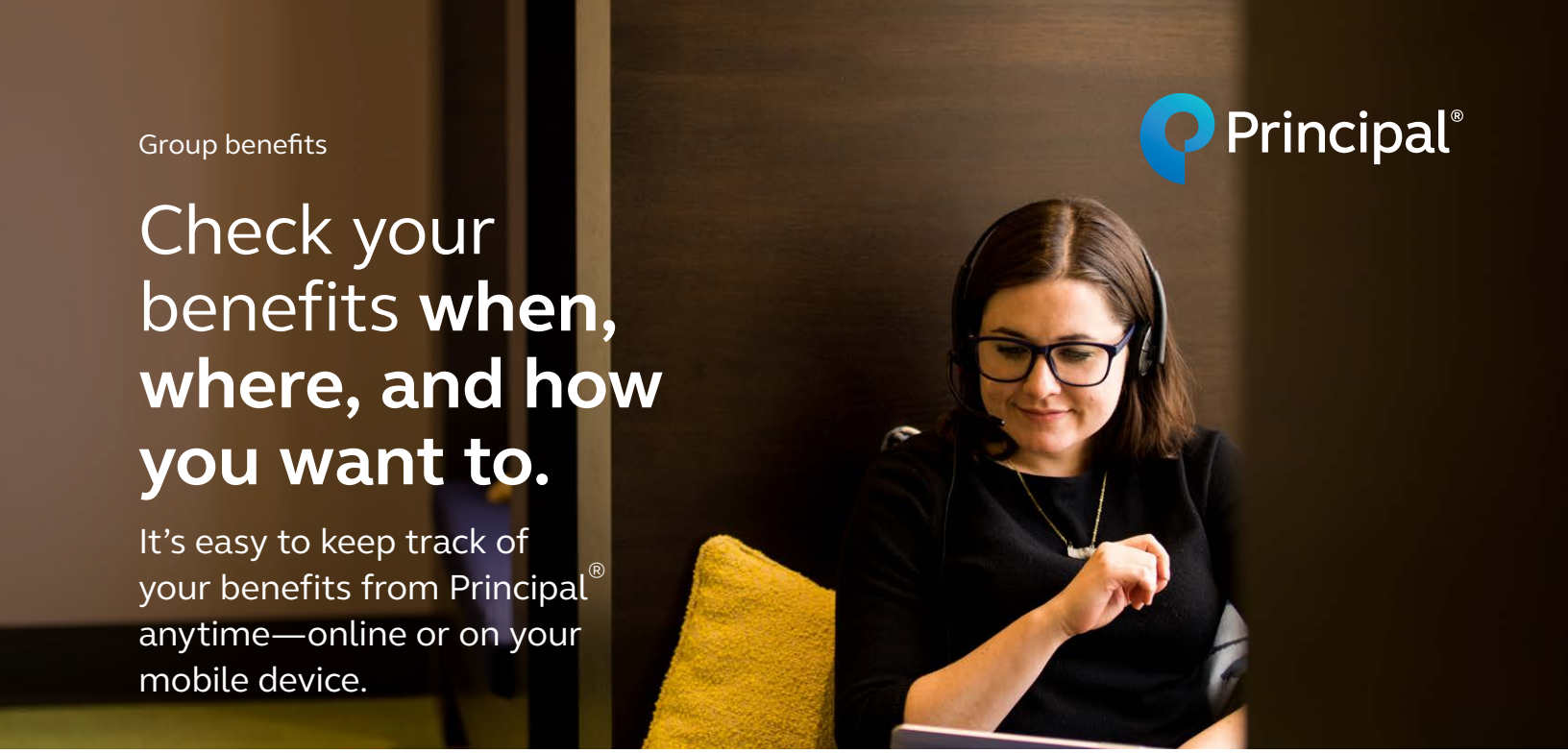
OR

If you have questions or need assistance enrolling, reach out to:

Michelle Matt
Your Dedicated Client Relations Manager

michelle@theclemonsco.com
call 850-763-4451 (Phone)
850-769-5110 (Fax)
1-800-207-8046 ext. 24

This benefit summary provides selected highlights of the employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.



Group benefits

Check your benefits **when, where, and how you want to.**

It's easy to keep track of your benefits from Principal® anytime—online or on your mobile device.

Start by creating your account

1 | From your favorite browser, go to **principal.com** and select Log In. Or, download the **Principal® app** for free from the App Store or Google Play.

2 | Select **Individual,** then **Create an account.**

3 | Enter **personal information,** such as your first and last name, date of birth, and phone number. ID number and primary zip code are optional.

4 | Create a **username** and **password,** and provide an **email** address.

5 | You'll receive an email within a few minutes to **confirm** your account is ready to go. You can access your account information anytime, 24/7, with the username and password you've just set.

Manage your benefits on principal.com and the Principal® app

After logging in, you can manage your benefits and other Principal products you have when, where, and how it's convenient for you. Depending on your coverages, you can:

- View and manage claims.
- Get a 24-month history of your explanation of benefits (EOB).
- Access your summary of benefits, as well as benefit booklets.
- Find a list of covered dependents.
- View your dental and/or vision ID card, including dependent(s) names.
- Search for and contact a network dentist.
- Find discounts and services.
- Calculate coverage needs and more.

Keeping your account information safe

Your information is important to us. That's why we use verification codes to prevent others from accessing your account, even if they have your password. The first time you log in—on principal.com or the mobile app—you'll need to choose how you'll receive the codes.

If you log in from an unrecognized device, forget your password, or we notice anything out of the ordinary, the codes help us confirm it's really you accessing your account.

Principal®

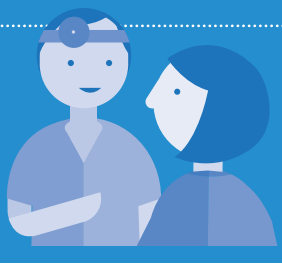
Simplify your dental care experience

Let's face it, for many of us, visiting the dentist isn't always our favorite activity. That's why the insurance side of the experience should be simple—and we get that.

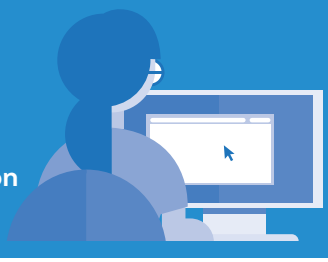
This handy step-by-step guide can help you better understand your dental insurance journey.

Path 1
You need a routine visit

Path 2
You need dental work



Path 3
You need more information



Path 1: You need a routine visit

They say an ounce of prevention is worth a pound of cure. Seeing your dentist regularly for routine care helps you avoid problems down the line. **So, how do you make it happen?**

Find a network dentist.

Your out-of-pocket costs will be lower and you may even qualify for in-network discounts. How?

Check your ID card for your network **and** Go online to **principal.com/dentist** **or** Give us a call: **800-247-4695**

Confirm network participation.

When you schedule your appointment, confirm the provider is still in the network.

Make sure you're eligible.

Depending on your policy, it may be too soon to schedule an appointment.

Example 1
One check-up every 6 months

Jan — Dec

April 3
1st check-up

Oct. 3
Next eligible

Example 2
Check-ups twice a year

Jan — Dec

April 3
1st check-up

Eligible for one more check-up anytime until the **next Jan. 1**

Path 2: You need dental work

When your teeth need special treatment, it's up to you and your dentist to decide what work needs to be done.

What are your next steps?

1. Talk to your dentist about submitting a **pre-determination.**
2. Remind your dentist to provide supporting documentation.
3. Plan for a processing period of 10 to 14 business days.
4. Call us with questions at 800-247-4695.

What's a pre-determination?

It's a review of the claim by a licensed dentist to determine if the procedure is dentally necessary and will be covered by your insurance.

Why do I need one?

- Prevents surprises about what will be paid
- Details the costs we cover and what you're responsible for, such as deductible, co-insurance, or non-covered services

Path 3: You need more information

You're not in this alone. Have questions? We have answers.

Call us at 800-247-4695.

Send us a note via principal.com/contact us.

We'll get back to you within 24-48 hours.

Download the Principal Mobile smart phone app!

It's free and compatible with both Android and Apple devices. Look for it in Google Play or the Apple App Store.

Visit us on the web at principal.com/individuals/insure/get-started.

Principal®

Principal®

Vision insurance

Set your sights on healthy eyes.

Vision coverage that gives you choice of provider options for exams and eyewear

Everyone likes choices—especially when it comes to choosing your eye doctor and eyewear. Managed care vision insurance through Principal® and VSP® Vision Care puts you in the driver's seat.

Whether you're looking to visit an eye doctor or want to enjoy the convenience of online shopping, we've got you covered. Through an established network of providers, you'll get access to a high level of care and low out-of-pocket costs.[1]

VSP

Full-service locations with satisfaction guaranteed, offering a WellVision Exam® that can help detect signs of eye and overall health conditions, such as diabetes. Plus, a wide selection of eyewear and 24-hour access to emergency care.

- Early morning, evening, and weekend appointments offered by 91% of providers
- Extra savings and offers on preferred frame brands, contact lens services, and sunglasses
- Integrated medical management with VSP's Health-Focused Care
- Extra $20 to spend on featured frame brands, like bebe®, Calvin Klein®, Flexon®, Lacoste®, Nike®, Nine West,® and more[2]
- 20% off any amount over the allowance for frames

ONLINE SHOPPING

With Eyeconic®, you get the convenience of shopping online plus the personal touch from a VSP network doctor. Visit eyeconic.com®.

- Free shipping and returns
- Virtual try on tool
- Free frame adjustment or contact lens consultation
- All-inclusive pricing
- Average savings of $220 (compared to out-of-pocket expenses without VSP insurance)

RETAIL CHAINS

5,500+ retail partner chain locations, plus 4,700+ independent chain locations nationwide

- No required forms—you pay only copays, costs over coverage amounts, and/or for non-covered option
- Retail partners include Walmart, Sam's Club, Costco® Optical, Visionworks®, Wisconsin Vision, Heartland Vision, RxOptical®, Cohen's Fashion Optical®, Pearle Vision, and Shopko.

OUT-OF-NETWORK

Coverage includes a reimbursement schedule for any out-of-network provider.

Visit **vsp.com** or call **800-877-7195** to submit claims.

How to access your vision benefits

It's as easy as 1-2-3 to look up your benefits, locate VSP in-network eye care providers near you, and use your benefits.

1 Access your benefits.

› Visit **vsp.com** and click on "Create an account."

› Follow the online Member Registration form using your member ID found on your vision ID card.

2 Search for providers.

› Visit **vsp.com** or **principal.com/vsp.**

› Enter your ZIP code or address and click Search.

3 Use your benefits.

› Schedule your appointment with your provider of choice.

› At your appointment, present your vision ID card and remind the provider to look up your benefits using the member ID on your card (not your Social Security number).

Prefer to access your vision ID card on your mobile device? It's simple.

1. Set up your username and password at **principal.com**.
2. Download the Principal® app from the App Store® or Google Play™.
3. Log in to the app using your principal.com username and password.

Let's connect

Contact your employer or call the VSP member services line at **800-877-7195**.

[1] Based on your coverage options and national averages for eye exams and most commonly purchased brands.

[2] Only available to VSP members with applicable policy benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by policy and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your policy type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Principal®

vsp vision care

principal.com

Managed care vision insurance is provided through **Principal Life Insurance Company®,** Des Moines, IA 50392, and is administered by VSP. Principal Life is a member of the Principal Financial Group®.

This policy has limitations and exclusions. For costs and complete details coverage details, ask your employer.

This flyer is not approved for use in Arizona. Oregon policy form GC 9000 (1013).

The Principal® app is available for iPhone® and Android™. Apple® and iPhone are registered trademarks of Apple Inc. Android is a trademark of Google LLC. VSP is not a member of the Principal Financial Group®.

Spanish SP1882-04 | 09/2022 | 2396430-092022

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: **$10,000** Per Person/**$20,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$8,200** Per Person/**$16,400** Family. Out-Of-Network: **$16,400** Per Person/**$32,800** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: No Charge, Deductible does not apply - Visits 1-3;$30 Copay per remaining Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $60 Copay per Visit/ Virtual Visits: $60 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	50% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: $60 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	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	20% Coinsurance up to a maximum of $200 per Prescription at retail, 20% Coinsurance up to a maximum of $500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Physician Services: Deductible + 20% Coinsurance/ Facility: $350 Copay per Visit	Physician Services: In-Network Deductible + 20% Coinsurance/ Facility: $350 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;$100 Copay	Deductible + $100 Copay per Visit	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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)	
		per remaining Visit/ Urgent Care Visits: $100 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$60 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$60 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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)	
				and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- 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/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. 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 1-800-352-2583. 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. 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.

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.

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.

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	**$5,000**
Specialist Copayment	**$60**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$70
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,830**

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

The plan's overall deductible	**$5,000**
Specialist Copayment	**$60**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$5,000**
Specialist Copayment	**$60**
Hospital (facility) Coinsurance	**20%**
Other Copayment	**$350**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: **$4,500** Per Person.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,650** Per Person/**$13,300** Family. Out-Of-Network: **$20,000** Per Person/**$20,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: $35 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	50% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$200 Copay per Visit	Deductible + 50% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	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	20% Coinsurance up to a maximum of $200 per Prescription at retail, 20% Coinsurance up to a maximum of $500 per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: $300 Copay per Visit	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 50% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 50% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Emergency medical transportation	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;Deductible + 50% Coinsurance per remaining Visit/ Urgent Care Visits:	Deductible + 50% Coinsurance	————none————

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)	
		Deductible + 50% Coinsurance		
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 Copay per Admission	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$50 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Childbirth/delivery facility services	$1,500 Copay per Admission	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$50 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 25 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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)	
	Hospice services	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 25 visits
- 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/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. 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 1-800-352-2583. 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. 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.

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.

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.

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	**$1,500**
Specialist Copayment	**$50**
Hospital (facility) Copayment	**$1,500**
Other No Charge	**$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$1,500**
Specialist Copayment	**$50**
Hospital (facility) Copayment	**$1,500**
Other Coinsurance	**50%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$1,500**
Specialist Copayment	**$50**
Hospital (facility) Copayment	**$1,500**
Other Coinsurance	**50%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$2,000** Per Person/**$6,000** Family. Out-of-Network: **$6,000** Per Person/**$18,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100** In-Network/ **$500** Out-of-Network Per Admission Deductible. 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?	In-Network: **$5,500** Per Person/**$11,000** Family. Out-Of-Network: **$11,000** Per Person/**$22,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: $35 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $65 Copay per Visit/ Virtual Visits: $65 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	50% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: $50 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$300 Copay per Visit	Deductible + 50% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$60 Copay per Prescription at retail, $150 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	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.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: $65 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Physician Services: Deductible + 20% Coinsurance/ Facility: $300 Copay per Visit	Physician Services: In-Network Deductible + 20% Coinsurance/ Facility: $300 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not	Deductible + $70 Copay per Visit	————none————

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)	
		apply - Visits 1-2;$70 Copay per remaining Visit/ Urgent Care Visits: $70 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Per Admission Deductible + Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$65 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Per Admission Deductible + Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	$65 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 50%	Coverage limited to 60 days.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Coinsurance	
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- 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/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. 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,

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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. 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.

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.

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.

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	**$2,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$2,100
Copayments	$80
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,540**

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

The plan's overall deductible	**$2,000**
Specialist Copayment	**$65**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$2,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**20%**
Other Copayment	**$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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000** Per Person/**$3,000** Family. Out-of-Network: **$3,000** Per Person/**$6,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	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 in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: $25 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $45 Copay per Visit/ Virtual Visits: $45 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	50% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: $50 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$200 Copay per Visit	Deductible + 50% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$30 Copay per Prescription at retail, $75 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$50 Copay per Prescription at retail, $125 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $150 Copay per Visit/ Hospital: Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: $45 Copay per Visit/ Hospital: $100 Copay per Visit	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: $100 Copay per Visit	————none————
If you need immediate medical attention	Emergency room care	Physician Services: $100 Copay per Visit/ Facility: $200 Copay per Visit	Physician Services: $100 Copay per Visit/ Facility: $200 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2;$50 Copay per remaining Visit/ Urgent Care Visits: $50 Copay per Visit	Deductible + $50 Copay per Visit	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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 + 20% Coinsurance	$3,500 Copay per Admission	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	$100 Copay per Visit	$100 Copay per Visit	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: $500 Copay per Admission	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$45 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$100 Copay per Visit	$100 Copay per Visit	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	$3,500 Copay per Admission	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	$45 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 50% Coinsurance	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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 your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

- Chiropractic care - Limited to 35 visits
- 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/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. 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 1-800-352-2583. 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. 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.

Does this plan provide Minimum Essential Coverage? Yes

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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 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.

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	**$1,000**
Specialist Copayment	**$45**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	**$1,000**
Specialist Copayment	**$45**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,000**
Specialist Copayment	**$45**
Hospital (facility) Coinsurance	**20%**
Other Copayment	**$200**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,600** Per Person. Out-of-Network: **$3,200** Per Person.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$5,000** Per Person. Out-Of-Network: **$10,000** Per Person.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge after Deductible/ Primary Care Visits: Deductible + 20% Coinsurance/ Virtual Visits: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: No Charge after Deductible/ Specialist: Deductible + 20% Coinsurance/ Virtual Visits: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	40% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: No Charge after Deductible/ Independent Clinical Lab: No Charge after Deductible/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	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.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge after Deductible/ Urgent Care Visits: Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a	Facility fee (e.g., hospital	Deductible + 20% Coinsurance	Deductible + 40%	Inpatient Rehab Services limited to 30 days.

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)	
hospital stay	room)		Coinsurance	
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 20% Coinsurance	Physician Services: In-Network Deductible + 20% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40%	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

- Chiropractic care - Limited to 35 visits
- 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/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. 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 1-800-352-2583. 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. 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.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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.

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.

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	**$1,600**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

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

The plan's overall deductible	**$1,600**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$1,100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	**$1,600**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

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

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

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. 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 or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,200** Per Person/**$3,200** Family. Out-of-Network: **$6,400** Per Person/**$6,400** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$5,400** Per Person/**$5,400** Family. Out-Of-Network: **$10,800** Per Person/**$10,800** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge after Deductible/ Primary Care Visits: Deductible + 20% Coinsurance/ Virtual Visits: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: No Charge after Deductible/ Specialist: Deductible + 20% Coinsurance/ Virtual Visits: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	40% Coinsurance	Physician administered drugs may have higher cost share. 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)	Value Choice Specialist: No Charge after Deductible/ Independent Clinical Lab: No Charge after Deductible/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	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.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge after Deductible/ Urgent Care Visits: Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a	Facility fee (e.g., hospital	Deductible + 20% Coinsurance	Deductible + 40%	Inpatient Rehab Services limited to 30 days.

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)	
hospital stay	room)		Coinsurance	
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 20% Coinsurance	Physician Services: In-Network Deductible + 20% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40%	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

- Chiropractic care - Limited to 35 visits
- 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/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. 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 1-800-352-2583. 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. 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.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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.

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.

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	**$3,200**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,200
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,970**

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

The plan's overall deductible	**$3,200**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,200
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,880**

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

The plan's overall deductible	**$3,200**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

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)
civilrightscoordinator@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 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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 โดยติดต่อหมายเลขโทรฟรี **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 (TTY: 1-800-955-8770) 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. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.