**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.benefits.keysschools.schoolfusion.us or by calling Florida Blue at 1-800-664-5295 or MedImpact at 1.844.348.8505

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,250** in-network per person; **$2,500** family/ out-of-network is combined with in-network **deductible**. Doesn't apply to in-network preventive care. **Prescription Drug** deductible is **$100** per person or **$200** per family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible |
| **Are there other deductibles for specific services?** | **No**. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | **Yes. $6,850** in-network per person; **$13,700** family/out-of-network is combined. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit** |
| **Is there an overall annual limit on what the plan pays?** | **No**. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | **Yes**. For a list of **participating providers**, see www.floridablue.com or call 1-800-664-5295.<br>For a list of **participating pharmacies** see www.MedImpact.com or call 1.844.348.8505. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | **No.** | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | **Yes.** | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services.** |

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

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 Copayment | $50 Copayment | Additional cost shares may apply for physician administered drugs. |
| | Specialist visit | $50 Copayment | $70 Copayment | |
| | Other practitioner office visit | $50 Copayment | $70 Copayment | |
| | Preventive care /screening/immunization | $0 | $50 Family Physician/$70 Specialist Copayment | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $0 for Independent Clinical Lab, $50 Copayment for Independent Diagnostic Testing Center, Deductible + 25% Coinsurance for Outpatient Hospital Facility | Deductible + 40% Coinsurance for Independent Clinical Lab, Independent Diagnostic Testing Center, and Outpatient Hospital Facility | Prior authorization may be required. Quest Diagnostics is the In-network provider for Lab services. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | $200 Copayment for Family Physician and Independent Diagnostic Testing Center, Deductible + 25% Coinsurance for Outpatient Hospital Facility | $200 Copayment for Family Physician and Independent Diagnostic Testing Center, Deductible + 40% Coinsurance for Outpatient Hospital Facility | Prior authorization may be required. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.MedImpact.com. | Generic drugs | $15 Copayment after Ded . | Not Covered | None |
| | Preferred brand drugs | $45 Copayment after Deductible | Not Covered | Patient will pay the brand copayment plus the cost difference between the branded product and the generic if they elect the brand product when an FDA approved generic is available. |
| | Non-preferred brand drugs | $65 Copayment after Deductible | Not Covered | Patient will pay the brand copayment plus the cost difference between the branded product and the generic if they elect the brand product when an FDA approved generic is available. |
| | Specialty drugs | Covered at appropriate Copayment after Ded. | Not Covered | Prior authorization may be required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $250 Copayment for Ambulatory Surgery Center; Deductible + 25% Coinsurance for Outpatient Hospital Facility | Deductible + 40% Coinsurance for Ambulatory Surgery Center and Outpatient Hospital Facility | Option 2 hospitals may have higher cost shares. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Physician/surgeon fees | $40 Family Physician / $50 Specialist Copayment for Ambulatory Surgery Center; $50 Copayment for Outpatient Hospital Facility | Deductible + 40% Coinsurance for Ambulatory Surgery Center; $50 Copayment for Outpatient Hospital Facility | None |
| **If you need immediate medical attention** | Emergency room services | $350 Copayment | $350 Copayment | None |
| | Emergency medical transportation | Deductible + 25% Coinsurance | In network Deductible + 25% Coinsurance | None |
| | Urgent care | $50 Copayment | Deductible + $50 Copayment | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible + 25% Coinsurance | Deductible +40% Coinsurance | Inpatient Rehabilitation Services are limited to 30 days per benefit period. Option 2 hospitals may have higher cost shares. |
| | Physician/surgeon fee | $50 Copayment | $50 Copayment | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $50 for Specialist Office; Deductible + 25% Coinsurance for Outpatient Hospital Facility | $70 for Specialist Office; Deductible + 40% Coinsurance for Outpatient Hospital Facility | Prior authorization may be required. Option 2 hospitals may have higher cost shares. |
| | Mental/Behavioral health inpatient services | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Option 2 hospitals may have higher cost shares. |
| | Substance use disorder outpatient services | $50 for Specialist Office; Deductible + 25% Coinsurance for Outpatient Hospital Facility | $70 for Specialist Office; Deductible + 40% Coinsurance for Outpatient Hospital Facility | Prior authorization may be required. Option 2 hospitals may have higher cost shares. |
| | Substance use disorder inpatient services | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Option 2 hospitals may have higher cost shares. |

| | | | | |
|---|---|---|---|---|
| **If you are pregnant** | Prenatal and postnatal care | $50 Copayment | $70 Copayment | None |
| | Delivery and all inpatient services | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Option 2 hospitals may have higher cost shares. |
| **If you need help recovering or have other special health needs** | Home health care | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Coverage is limited to 30 visits per benefit period. |
| | Rehabilitation services | $50 Copayment for Specialist Office and Outpatient Rehabilitation Facility; $50 Copayment for Outpatient Hospital Facility (Option 1), $70 Copayment for Option 2 Outpatient Hospital Facility | $70 Copayment for Specialist Office, and Outpatient Rehabilitation Facility; Deductible + 40% Coinsurance for Outpatient Hospital Facility | Outpatient Rehabilitation Services: coverage is limited to 122 visits per benefit period (includes up to 26 Spinal Manipulations). |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | Coverage is limited to 60 days per benefit period. |
| | Durable medical equipment | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | None |
| | Hospice service | Deductible + 25% Coinsurance | Deductible + 40% Coinsurance | None |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | None |
| | Glasses | Not Covered | Not Covered | None |
| | Dental check-up | Not Covered | Not Covered | None |

## Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatments
- 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 Private-duty nursing
- Weight loss programs

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

- Acupuncture
- Most coverage provided outside the United States. See www.bcbs.com/already-a-member/coverage-home-and-away.html
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Chiropractic care – limited as above
- TeleDoc Services - NEW!! 24/7 Telephonic Access to a Physician

## Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the Employee Benefits Department, Monroe County School District at 305-293-1400 ext. 53340 or you may contact FloridaBlue at 1-800-664-5295. You may also contact your state insurance department at **1-877-693-5236**, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Employee Benefits Department, Monroe County School District at 305-293-1400 ext. 53340.

For more information on your rights to a **grievance** or **appeal**, contact FloridaBlue at 1-800-664-5295. For pharmacy appeals you can contact MedImpact at 1.844.348.8505. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform, state insurance department at 1-877-693-5236.
For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al FloridaBlue: 1-800-664-5295; MedImpact 1.844.348.8505.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa FloridaBlue: 1-800-664-5295; MedImpact 1.844.348.8505.

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** FloridaBlue: 1-800-664-5295; MedImpact 1.844.348.8505.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' FloridaBlue: 1-800-664-5295; MedImpact 1.844.348.8505.

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

# About these Coverage Examples:

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

**This is not a cost estimator.**

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

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,150
- **Patient pays** $2,390

**Sample care costs:**

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

**Patient pays:**

| | |
|---|---|
| Deductibles | $1020 |
| Copays | $100 |
| Coinsurance | $1,120 |
| Limits or exclusions | $150 |
| **Total** | **$2,390** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,220
- **Patient pays** $2,180

**Sample care costs:**

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

**Patient pays:**

| | |
|---|---|
| Deductibles | $1100 |
| Copays | $680 |
| Coinsurance | $320 |
| Limits or exclusions | $80 |
| **Total** | **$2,180** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

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

## What does a Coverage Example show?

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

## Does the Coverage Example predict my own care needs?

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

## Does the Coverage Example predict my future expenses?

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

## Can I use Coverage Examples to compare plans?

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

## Are there other costs I should consider when comparing plans?

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