The School Board of Polk County

Coverage For: Individual + Family **Plan Type:** PPO

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, call 1-855-630-6824 or visit us at FL.ExploreMyPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance after overall deductible, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-630-6824 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$900/ individual or $1,800 family in-network. $1,500/ individual or $3,000 family out-of-network.	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 services in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance after overall deductible 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50/individual for prescription drug coverage. 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?	For in-network $5,000 individual / $9,000 family. Separate Prescription Drug out-of-pocket maximum: For in-network $1,600 individual / $4,200 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 limits has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, cost-sharing for most out-of-network benefits, pharmacy coinsurance, pharmacy deductible, pre-certification penalties, pharmacy copays and payments made by drug manufacturer assistance programs.	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 FL.ExploreMyPlan.com or call 1-855-630-6824 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 after overall deductible** costs shown in this chart are after overall 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	$50 copay/visit Deductible does not apply	40% coinsurance after overall deductible	Precertification is required for some provider administered drugs; office visits and consultations with an Embold Designated High Performer subject to $35 physician copay; if no precertification is obtained, no benefits are available
	Specialist visit	$50 copay/visit Deductible does not apply	40% coinsurance after overall deductible	
	Preventive care/screening/ immunization	No Charge Deductible does not apply	40% coinsurance after overall deductible	Please visit FL.ExploreMyPlan.com/FLPreventiveServices; additional services are available. 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)	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Cost-sharing does not apply to lab work processed through Quest Diagnostics; benefits listed are physician services; facility benefits are also available; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	20% coinsurance after overall deductible	40% coinsurance after overall deductible	

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	Tier 1 Drugs	$8 copay (retail) $20 copay (mail order) Deductible does not apply	Not Covered	Prior authorization required for specific drugs; Tier 3 and Tier 4 retail drugs are subject to $50 drug deductible; if you purchase a brand name medication when a generic is available, you will pay the generic copay plus the difference in the cost between the brand and generic medication; the cost share for drugs on the FlexAccess Drug List may vary based on available drug manufacturer assistance;; if assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program; go to **FL.ExploreMyPlan.com/FLFlexAccessDrugList** for a list of retail drugs in the FlexAccess Program; Value Based Drugs are covered 100%, no copay or deductible. View the **SourceRx 1.0 Drug List** that applies to the plan at **FL.ExploreMyPlan.com/druglist**
	Tier 2 Drugs	$8 copay (retail) $20 copay (mail order) Deductible does not apply	Not Covered	
	Tier 3 Drugs	$40 copay and 10% coinsurance after overall deductible/up to maximum of $80 per prescription (retail) $125 copay (mail order) Subject to $50 drug deductible	Not Covered	
	Tier 4 Drugs	$80 copay and 10% coinsurance after overall deductible/up to maximum of $160 per prescription (retail) $200 copay (mail order) Subject to $50 drug deductible	Not Covered	
	Tier 5 Drugs (generic or preferred specialty)	$80 copay (retail) Subject to $50 drug deductible	Not Covered	
	Tier 6 Drugs (non-preferred specialty)	$160 copay (retail) Subject to $50 drug deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	20% coinsurance after overall deductible	40% coinsurance after overall deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after overall deductible	20% coinsurance after in-network overall deductible	Physician charges will apply
	Emergency medical transportation	20% coinsurance Deductible does not apply	20% coinsurance Deductible does not apply	None
	Urgent care	$50 copay/visit Deductible does not apply	40% coinsurance after overall deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	20% coinsurance after overall deductible	20% coinsurance after in-network overall deductible	Subject to in-network overall deductible

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 mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit No overall deductible	40% coinsurance after in-network overall deductible	Benefits listed are physician services; additional benefits are available; may require higher patient responsibility; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Inpatient services	Physician 20% coinsurance after overall deductible Inpatient Hospital 20% coinsurance after overall deductible	20% coinsurance after in-network overall deductible	
If you are pregnant	Office visits	20% coinsurance after overall deductible and $50 copay at initial visit	40% coinsurance after overall deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance after overall deductible or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% coinsurance after overall deductible and $50 copay at initial visit	40% coinsurance after overall deductible	
	Childbirth/delivery facility services	20% coinsurance after overall deductible	40% coinsurance after overall deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Limited to 20 visits per benefit period; benefits are also available for home infusion services; precertification may be required; if no precertification is obtained, no benefits are available
	Rehabilitation services	Physician office and outpatient Rehab Center: $50 copay/visit No overall deductible Inpatient Rehab: 20% coinsurance after overall deductible	40% coinsurance after overall deductible	35 visits/year; includes occupational, physical and speech therapy; includes up to 26 spinal manipulations, for chiropractic services and therapies, once visit maximum has been meet, no additional spinal manipulations for that calendar year are covered
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Limited to 60 days per benefit period; precertification may be required; if no precertification is obtained, no benefits are available
	Durable medical equipment	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	20% coinsurance after overall deductible	40% coinsurance after overall deductible	Precertification may be required; if no precertification is obtained, no benefits are available

If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not covered; member pays 100%
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not Covered	Not Covered	Not covered; member pays 100%

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)
- Dental check-up, child
- Eye exam, child
- Glasses, child
- Habilitation services
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- 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 26 manipulations/visits per member per benefit period)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Hearing Aids (must be medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after overall it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. If coverage is insured, contact your State insurance regulator regarding your possible rights to continuation coverage under State Law. 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: Blue Cross and Blue Shield of Florida at 1-855-630-6824.

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 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.

* For more information about limitations and exceptions, see the plan or policy document at FL.ExploreMyPlan.com.

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 (deductible, 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**	$900
Specialist copayment	$50
Hospital (facility) **coinsurance**	20%
Other **copay/coinsurance**	$50/20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,260

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

The **plan's** overall **deductible**	$900
Specialist copayment	$50
Hospital (facility) **coinsurance**	20%
Other **copay/coinsurance**	$50/20%

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*	$300
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,040

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

The **plan's** overall **deductible**	$900
Specialist copay	$50
Hospital (facility) **coinsurance**	20%
Other **copay/coinsurance**	$50/20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,400

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

* For more information about limitations and exceptions, see the plan or policy document at FL.ExploreMyPlan.com.

Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Florida provides to your employer.

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Florida complies 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 and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at:

Blue Cross and Blue Shield of Florida, Birmingham Service Center, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-844-594-6009, 711 (TTY), 1-205-220-2984 (fax), Grievance1557@exploremyplan.com (email). If you need help filing a grievance, our 1557 Compliance 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, or 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.

Foreign Language Assistance

Spanish:ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencialingüística. Llame al 1-844-594-6009 (TTY: 711)

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-594-6009 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-594-6009 (TTY: 711).

Chinese: 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1-844-594-6009（TTY: 711）。

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.Ligue para 1-844-594-6009 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposésgratuitement. Appelez le 1-844-594-6009 (ATS: 711).

Tagalog:PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ngtulong sa wika nang walang bayad. Tumawag sa 1-844-594-6009 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-594-6009 (телетайп: 711).

Arabic:اتصل بـ .إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك :انتباه

1-844-594-6009 (الهاتف النصي: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-844-594-6009 (TTY: 711)번으로 전화해 주십시오.

Italian:ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-594-6009 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-594-6009 (TTY: 711).

Polish:UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-594-6009 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-844-594-6009 પર કૉલ કરો (TTY: 711).

Thai:เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-594-6009 (TTY: 711)