

# Summary of PPO Benefits

**Benefit Period April 1, 2026 -March 31, 2027**

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.



## ICUBA Preferred PPO Plan

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
<b>Healthcare Coverage Summary</b>		
Deductible Per Benefit Period (PBP)		
Individual	\$3,000	\$4,500
Family	\$6,000	\$11,750
Coinsurance	20%	40%
<i>Out-of-Pocket Maximums PBP</i> <i>(includes medical deductible, medical coinsurance, and medical copays)</i>		
Individual	\$7,400	\$10,900
Family	\$14,800	\$21,800
Lifetime Maximum	No Maximum	
Physician Office Visits <i>(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)</i>	\$15 copay (not subject to deductible)	40% after deductible
Total Care Physician Office Visit <i>(Internist, Family Practice, Pediatrician)</i>	0% (not subject to deductible)	Not Applicable
Embold Physician Office Visit	0% (not subject to deductible)	Not Applicable
<i>*When you see an Embold Health-designated provider, you may be asked to pay the copay at the time of your visit. Once the claim is processed and you receive your Explanation of Benefits (EOB) from BCBS, the copay will be refunded, resulting in a \$0 copay for the visit.</i>		
Teladoc Telemedicine Visit	0% after \$5 copay	Not Applicable
Maternity Office Visit Benefit <i>(initial OB visit only)</i>	\$15 copay (not subject to deductible)	40% after deductible
Specialist Office Visits	\$35 copay (not subject to deductible)	40% after deductible
Independent Clinical Labs (medically necessary) <sup>1</sup>		
Quest Diagnostics and office visits	0% (not subject to deductible)	40%
Outpatient Facility (Hospital setting) <sup>2</sup>	20% coinsurance	after deductible
Preventive Care <i>Annual Physical and Gynecological exam</i>	0% (not subject to deductible)	Not Covered
Chlamydia and STD tests	0% (not subject to deductible)	Not Covered
PAP tests	0% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	0% (not subject to deductible)	Not Covered
Mammograms and Ultrasounds of the Breast	0% (not subject to deductible)	Not Covered
Urinalysis	0% (not subject to deductible)	Not Covered
Venipuncture/Conveyance Fee	0% (not subject to deductible)	Not Covered
General Health Blood Panel <i>Glucose Test, Lipid Panel, Cholesterol, and ALT/AST</i>	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services <i>(e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)</i>	0% (not subject to deductible)	Not Covered
Allergy Injections	0% (not subject to deductible)	40% after deductible
Emergency Room Services	0% after \$500 copay (waived if admitted)	
Medically Necessary Emergency Transportation	0% after \$250 copay	
Convenient Care Clinic (Retail) <i>Minute Clinic- CVS/Healthcare Clinic - Walgreens</i>	0% after \$10 copay	
Urgent Care Center	0% after \$30 copay	
Hospital Expenses Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
Outpatient Surgery Office Setting <i>(Physician or Specialist)</i>	20% (not subject to deductible)	40% after deductible
Outpatient Facility	20% after deductible	40% after deductible
Related professional services	20% after deductible	40% after deductible
Non-Emergent Surgeries with Lantern Please call 855-200-2119 for this separate benefit	Deductible/Coinsurance waived when utilizing Lantern services and network	Not Covered
Infertility Services <i>(Counseling and testing to diagnose only)</i>	20% after deductible	40% after deductible
Outpatient Physical Therapy	\$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Outpatient Speech Therapy <i>(Restorative services only)</i>	\$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Outpatient Occupational Therapy	\$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Spinal Manipulation	\$20 copay (not subject to deductible) Limit: 60 visits/ benefit period	40% after deductible
Diagnostic Services <i>(X-Ray and other tests)</i>	20% after deductible	40% after deductible
Outpatient Diagnostic Imaging <i>(MRI, MRA, CAT Scan, PET Scan)</i>	Allowed Charges up to \$500 Copay	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Prosthetic Appliances	20% after deductible	40% after deductible
<b>Hearing Care Services</b>		
Hearing aid screening/exam	20% (not subject to deductible)	
Hearing aid	20% after in-network deductible Combined limit: \$1,500/ benefit period	
Temporomandibular Joint Disorder <i>(Medical necessity required; excludes appliances and orthodontic treatment)</i>	20% after deductible	40% after deductible
Inpatient Rehabilitation	20% after deductible Limit: 60 days/ benefit period	40% after deductible
Skilled Nursing Rehabilitation	20% after deductible Limit: 60 days/ benefit period	40% after deductible
Home Health Care	20% after deductible	40% after deductible
Private Duty Nursing	20% after deductible	40% after deductible
Hospice: Inpatient and Outpatient	0% (not subject to deductible)	40% after deductible
<b>Mental Health and Substance Abuse Coverage Summary</b>		
Mental Health or Substance Abuse Inpatient	20% after deductible	40% after deductible
Outpatient	\$15 copay (not subject to deductible)	40% after deductible
Inpatient <sup>3</sup>	20% after deductible	40% after deductible
Mental Health Hospital Admission <sup>3</sup>	20% after deductible	40% after deductible
Substance Abuse Hospital Admission <sup>3</sup>	20% after deductible	40% after deductible
Residential <sup>3</sup> Residential Services focus on evaluating and stabilizing the patient. They help the patient learn effective ways to cope with the symptoms and impact of the patient's illness.	20% after deductible	40% after deductible
Inpatient Detoxification <sup>3</sup> Inpatient detoxification provides 24 hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. Patients typically stay in detoxification only as long as their withdrawal symptoms require 24 hour medical and nursing services.	20% after deductible	40% after deductible
Outpatient	\$15 copay (not subject to deductible)	40% after deductible

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
<b>Professional Counselling Sessions</b> Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.	\$15 copay (not subject to deductible)	40% after deductible
<b>Psychiatric Medication Evaluation</b>	\$15 copay (not subject to deductible)	40% after deductible
<b>Applied Behavioral Analysis Therapy<sup>3</sup></b> Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis.	\$15 copay (not subject to deductible)	40% after deductible
<b>Partial Hospitalization (PHP)<sup>3</sup></b> These programs are longer and more intensive than an IOP, usually 4-6 hours per day, 5-7 days per week. Services include physician and nursing services, as well as group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services. These programs are often used in lieu of an inpatient stay, or as a transition from an inpatient stay.	\$15 copay (not subject to deductible)	40% after deductible
<b>Outpatient Detoxification</b> Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.	\$15 copay (not subject to deductible)	40% after deductible
<b>Intensive Outpatient Sessions (IOP)</b> These planned and structured programs are usually 2-3 hours/day (or evening), and 3-7 days per week. They may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services.	\$15 copay (not subject to deductible)	40% after deductible

#### Pharmacy Benefit Coverage Summary<sup>4</sup>

Prescription Pharmacy Drug Tier	Retail: Up to 30 day supply	Retail or Mail: Up to 90 day supply
Low Cost Generics at the NSU Pharmacy	\$0 copayment	\$0 copayment
Low Cost Generics at all other network pharmacies	\$5 copayment	\$10 copayment
Preventive Generics <sup>5</sup>	\$0 copayment	
Generics: <sup>6</sup> <i>Tier 1 Medications on the Premium Formulary</i>	\$10 copayment	\$20 copayment
Preferred Brand: <sup>6</sup> <i>Tier 2 Medications on the Premium Formulary</i>	\$55 copayment	\$110 copayment
Non-Preferred Brand: <sup>6</sup> <i>Tier 3 Medications on the Premium Formulary</i>	\$95 copayment	\$190 copayment
Preferred Specialty Medication <sup>7</sup> <i>Required to use Optum Specialty Pharmacy</i>	20% coinsurance not to exceed \$500 per covered prescription	
Non-Preferred Specialty Medication <sup>7</sup> <i>Required to use Optum Specialty Pharmacy</i>	20% coinsurance not to exceed \$500 per covered prescription	

This summary does not constitute a contract for benefits, the information displayed here is only a summary of the benefits and programs available. Please review the Plan Document provided by your employer for a comprehensive list of covered services. Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.

1. Quest Diagnostic Labs is the In-Network Lab for BlueCross BlueShield of Florida.
2. Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center)
3. Services require prior-authorization
4. Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.
5. Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the \$0 copay)
6. The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.
7. Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products.

#### Customer Care

Provider	Number	Website
Florida Blue Care Connected	(855) 258-9029	<a href="https://member.myhealthtoolkitfl.com/">https://member.myhealthtoolkitfl.com/</a>
Florida Blue Nurse Case Manager	(855) 263-0675 ext. 40471	<a href="https://member.myhealthtoolkitfl.com/">https://member.myhealthtoolkitfl.com/</a>
Florida Blue Behavioral Health Case Manager	(800) 868-1032 ext. 25116	<a href="https://member.myhealthtoolkitfl.com/">https://member.myhealthtoolkitfl.com/</a>
Quest Diagnostics	(866) 697-8378	<a href="https://Questdiagnostics.com">https://Questdiagnostics.com</a>
Optum Specialty Pharmacy	(855) 258-9029	<a href="https://member.myhealthtoolkitfl.com/">https://member.myhealthtoolkitfl.com/</a>

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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ICUBAcares Pharmacist Advocate	(877) 286-3967	<a href="https://www.icubacares.org/">https://www.icubacares.org/</a>
Lantern	(855) 200-2099	<a href="http://my.lanternare.com">my.lanternare.com</a>
Hinge Health	(855) 902-2777	<a href="https://www.hingehealth.com/for/icuba">https://www.hingehealth.com/for/icuba</a>



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage visit <http://icubabenefits.org> or by calling 1-866-377-5102. 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 <https://www.healthcare.gov/sbc-glossary> or [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-258-9029 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$3,000</b> in-network per person; <b>\$6,000</b> family/ <b>\$4,500</b> out-of-network per person; <b>\$11,750</b> family.	You must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . The deductible starts over each April 1 <sup>st</sup> . See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Deductible doesn't apply to in-network: preventive care, Teladoc, office visits, prescription drugs, outpatient facility labs, or advanced imaging. Doesn't apply to in- or out-of-network: emergency room, urgent care, convenient care, or emergency transportation.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$7,400</b> in-network per person; <b>\$14,800</b> family/ <b>\$10,900</b> out-of-network per person/ <b>\$21,800</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://myhealthtoolkitfl.com">http://myhealthtoolkitfl.com</a> , contact Essential Advocate at 1-888-521-2583 or call BCBS customer service at 1-855-258-9029 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. See the chart starting on page 2 for how this plan pays different kinds of providers.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the specialist you choose without permission from this plan.


Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services** Coverage Period: 04/01/2026 – 03/31/2027  
**ICUBA: Preferred PPO Plan**

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic (No Deductible)</b>	Primary care visit to treat an injury or illness	\$15 Copayment/Visit	Deductible + 40% Coinsurance	Additional cost shares may apply for physician administered drugs.  Embold Health Primary Care, Pediatrician, Cardiology, Dermatology, Endocrinology, Ortho Joint-Spine, Gastroenterology, Neurology, Obstetrics and Gynecology, Podiatry, Pulmonology, Ophthalmology, Urology, General, Bariatric and Lung Cancer surgery. (Orthopedic/Neurosurgical). Visits Are Always Free.  Therapy and Chiropractic visits are limited to 60 each per Plan Year.  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	\$0 Copayment/Visit	Not Applicable	
	Embold Health	\$0 Copayment/Visit	Not Covered	
	Specialist visit	\$35 Copayment/Visit	Deductible + 40% Coinsurance	
	Convenient Care Clinic	\$10 Copayment/Visit	\$10 Copayment/Visit	
	Physical/Occupational/Speech Therapy and Chiropractor Visits	\$20 Copayment/Visit	Deductible + 40% Coinsurance	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**      **Coverage Period: 04/01/2026 – 03/31/2027**  
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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)	
	<a href="#">Diagnostic test</a> (blood work)	\$0 for Quest Diagnostic Laboratories; 20% Coinsurance for clinical outpatient facility labs	Deductible + 40% Coinsurance	Must be medically necessary.
<b>If you have a test</b>	X-Ray	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$500 Copay (or actual cost if less) for family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility	Deductible + 40% Coinsurance family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility	Prior Authorization required.
<b>If you need drugs to treat your illness or condition</b> <b>More information about prescription drug coverage is available at <a href="http://www.MyHealthToolkitFL.com">www.MyHealthToolkitFL.com</a></b> <b>(No Deductible)</b>  Out of pocket limit is \$2,000 in-network for individual, \$4,000 family. No limit for out-of-network.	Preferred Generic drugs	\$0 Copay/Prescription (retail 30 and 90-day at NSU pharmacy, NCPDP# 1082041) \$5 Copay/Prescription (retail 30-day) \$10 Copay/Prescription (retail 90-day) \$10 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	<b>Retail 30:</b> 30 day supply; <b>Retail 90:</b> 84-91 day supply; <b>Mail Order:</b> 84-91 day supply  <b>Specialty Drugs:</b> Certain medications used for treating complex health conditions must be obtained through the specialty pharmacy program. Manufacturer coupons may not be applied to copay for non-preferred specialty drugs.  Prescribed preventive generic medications to treat
	Non-Preferred Generic drugs	\$10 Copay/Prescription (retail 30-day) \$20 Copay/Prescription (retail 90-day) \$20 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Preferred brand drugs	\$55 Copay/Prescription (retail 30-day) \$110 Copay/Prescription (retail 90-day) \$110 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred brand drugs	\$95 Copay/Prescription (retail 30-day) \$190 Copay/Prescription (retail 90-day) \$190 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	

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**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**      **Coverage Period: 04/01/2026 – 03/31/2027**  
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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)	
	Preferred Specialty drugs	20% coinsurance not to exceed \$500 per prescription.	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	one of the conditions designated Essential Health Benefit by the Affordable Care Act, such as hyperlipidemia, have a \$0 copay. Certain additional requirements such as age, sex, and diagnosis may also need to be met.
	Non-Preferred Specialty drugs	20% coinsurance not to exceed \$500 per prescription.	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
<b>If you have outpatient surgery (Must meet Deductible)</b>	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance for Outpatient Hospital Facility	Deductible + 40% Coinsurance for Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None
<b>If you need immediate medical attention (No Deductible)</b>	Emergency room care	\$500 Copayment	\$500 Copayment	Waived if Admitted
	Emergency medical transportation	\$250 Copayment	\$250 Copayment	None
	Urgent care	\$30 Copayment/Visit	\$30 Copayment/Visit	None
	Teladoc Telemedicine	\$5 Copayment/Visit	Not Covered	None
<b>If you have a hospital stay (Must meet Deductible)</b>	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per benefit period.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	None

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>  Inpatient: <b>(Must Meet Deductible)</b> Outpatient: <b>(No Deductible)</b>  <b>For more information on Behavioral Health and Substance Abuse call: 1-800-868-1032</b>	Outpatient services	\$15 Copayment/Visit	Deductible + 40% Coinsurance	None
	Inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per Plan Year
<b>If you are pregnant</b>  <b>(In-network: Full deductible not required until delivery)</b>	Prenatal and postnatal care	\$15 Copayment (Initial Visit Only)	Deductible + 40% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
<b>If you need help recovering or have other special health needs</b>	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Rehabilitation services	\$20 Copayment/Visit for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 40% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Up to 60 combined visits per benefit period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior Authorization required
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Up to 60 visits per benefit period

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	Hospice services	No Charge	Deductible + 40% Coinsurance	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's glasses	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's dental check-up	Covered under Dental Plan	See Dental Plan	See Dental Plan

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Long-Term Care</li> <li>Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Routine Eye Care</li> <li>Infertility treatments</li> </ul>	<ul style="list-style-type: none"> <li>Dental care</li> <li>Routine Foot Care unless for treatment of diabetes</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Diagnosis of Infertility</li> <li>Bariatric Surgery with prior authorization</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Coverage provided outside the United States. See <a href="http://www.bluecardworldwide.com">www.bluecardworldwide.com</a></li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Non-emergency care when traveling outside the United States</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-258-9029. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa>. 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](http://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 questions about your rights, this notice, or assistance, you can contact any or all of the following:

- 1-855-258-9029 or visit us at [www.MyHealthToolkitFL.com](http://www.MyHealthToolkitFL.com)
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.  
 If you aren't clear about any of the underlined terms used in this form, see the Glossary.  
 You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.



**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.

**Language Access Services:**

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.

Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng customer service na makikita sa unang pahina ng paunawang ito.

Chinese:

如需中文服务，请致电列于本通知首页的客户服务号码。

T'áá Dinéji shil hane'go shiká i' doolwol ninizingo éi Nidaalnishigii Áká Anidaalwo'igii, customer service, bich'j' hodiilnih. Bik'ehgo bich'j' hane'igii éi díi naaltsoos neiyi'niligii akáa'gi siltsoozigii bikáá' iishjááh.

Navajo:

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

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Questions: Call 1-866-377-5102 or visit us at <http://icubabenefits.org>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at <https://healthcare.gov/SBC-Glossary> or call 1-855-258-9029 to request a copy.

**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)

**Managing Joe's type 2 Diabetes**

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

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist copayment](#) **\$35**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist copayment](#) **\$35**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist copayment](#) **\$35**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

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

**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*)

**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** **\$12,991**

**Total Example Cost** **\$7,690**

**Total Example Cost** **\$2,187**

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

<b>Cost Sharing</b>	
Deductibles	\$3,000
Copayments	\$35
Coinsurance	\$1,370
<b>The total Peg would pay is</b>	<b>\$4,405</b>

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

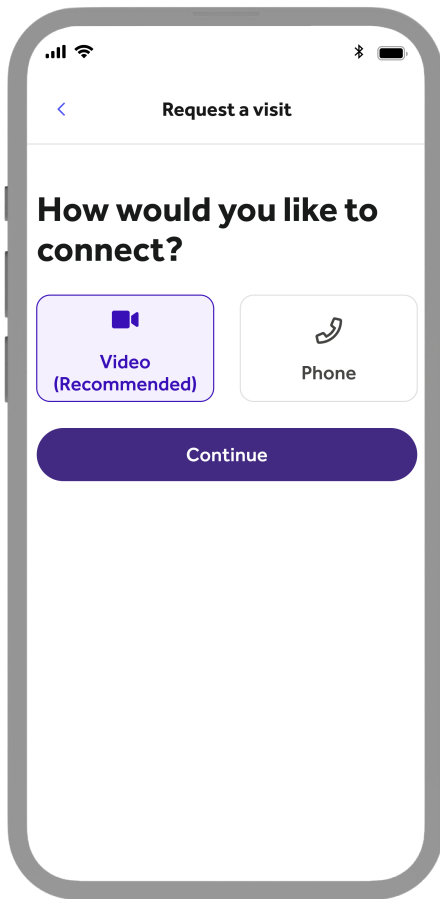
<b>Cost Sharing</b>	
Deductibles	\$0
Copayments	\$675
Coinsurance	\$55
<b>The total Joe would pay is</b>	<b>\$730</b>

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

<b>Cost Sharing</b>	
Deductibles	\$183
Copayments	\$500
Coinsurance	\$155
<b>The total Mia would pay is</b>	<b>\$838</b>

# The right care when you need it most

Here for you anytime, anywhere, by phone or video.



## Your Teladoc Health service(s):



### **24/7 Care** **\$5/visit**

Need care for non-urgent and common conditions? Get same-day virtual visits from anywhere. Teladoc Health's doctors, nurse practitioners and other healthcare providers can diagnose, treat and even prescribe medicine if needed.

- Allergies
- Bronchitis
- Flu
- COVID-19
- Pink eye
- Rashes
- Sinus infections
- Sore throats



### **Mental Health** **\$5/therapy visit** **\$5/psychiatry first visit** **\$5/psychiatry ongoing visit**

Have real conversations and see progress with a therapist of your choice. Available 7 days a week from the privacy of your home.

- Anxiety and depression
- Sleep issues
- Relationship conflicts
- Trauma and PTSD
- Medication management (psychiatry only)

## Get started

Visit [Teladochealth.com/go](https://Teladochealth.com/go)  
Call 1-866-789-8155 | Download the app  



## Lighting Your Path to the Right Surgical Care

### What is Lantern?

Lantern can help you get the best care when you need planned, nonemergency surgery. This money-saving benefit is available at no additional cost to you as part of your benefits.

## Here's What's Covered

In partnership with ICUBA, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your Lantern benefit. Your coverage includes:\*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

## Let Us Guide You Back to Health

### 3 Steps to the Best Care

#### STEP 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

#### STEP 2

Based on your needs, your Care Advocate will match you with a hand-picked list of excellent surgeons.

#### STEP 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

**Call Us to Learn More at 855 200 2119**



## Iluminando Su Camino a la Atención Quirúrgica Adecuada

### ¿Qué es Lantern?

Lantern puede ayudarlo a obtener la mejor atención cuando necesite una cirugía planificada que no sea de emergencia. Este beneficio de ahorro de dinero está disponible sin costo adicional para usted como parte de sus beneficios.

## Lo Que Está Cubierto

En colaboración con ICUBA cubrimos los costos más elevados de la cirugía, por lo que pagará menos por el procedimiento cuando utilice el beneficio de Lantern. La cobertura incluye lo siguiente:\*

- Apoyo y guía dedicados
- Asignación personalizada al cirujano que mejor se adapte a sus necesidades
- Consultas y citas con su cirujano de Lantern
- Tarifas de anestesia, procedimientos y establecimiento (hospital)

## Permítanos Devolverle Su Salud

### 3 Pasos para Recibir la Mejor Atención

#### PASO 1

Llame a un defensor de atención para comenzar. Le compartirá más información sobre sus beneficios y le preguntará sobre la atención que está buscando.

#### PASO 2

En función de sus necesidades, su defensor de atención le asignará una lista cuidadosamente seleccionada de excelentes cirujanos.

#### PASO 3

Después de elegir un cirujano, su defensor de atención lo ayudará a programar citas y lo guiará en cada paso de la experiencia.

**Llámanos al 855 200 2119**

\* Es posible que no se incluyan los gastos de pruebas, exámenes, diagnósticos por imágenes, equipos médicos durables y fisioterapia. Sin embargo, pueden estar cubiertos por su plan médico.



# Your partner for pain relief

With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best.

## Specialized care, personalized for you

Reduce everyday joint and muscle aches. Recover from an injury. Relieve pelvic pain and discomfort.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Access to Hinge Health Enso® a non-addictive, FDA-cleared wearable device to calm and soothe pain flare-ups in minutes

Scan the QR code or visit:  
[hinge.health/icuba-join](https://hinge.health/icuba-join)



Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.



**\$0**  
cost to you



A HINGE HEALTH EXCLUSIVE

### Meet Enso

The small device for pain relief on-the-go.

\*Eligibility to receive Hinge Health Enso is based on the program in which you are placed, fulfillment of clinical eligibility criteria, and completion of a qualifying number of exercise sessions.

Members and dependents 18+ enrolled in a Blue Cross Blue Shield ICUBA medical plan are eligible.



## Healthcare coverage when you are traveling or living abroad

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

### To take advantage of the program:

- Always carry your current member ID card.
- Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details. Coverage outside the United States may be different.
- If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
- If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. *Note: This number is different from the phone number listed below.*
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

In an emergency, go directly to the nearest hospital.

### To learn more about Blue Cross Blue Shield Global Core:

- Visit [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).
- Use the Blue Cross Blue Shield Global Core app for Android\*, iPhone, and iPod touch.\*\* (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.



The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

Blue Cross, Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard, BlueCard Worldwide, and Blue Cross Blue Shield Global are trademarks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

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