

# Summary of PPO Benefits

**Benefit Period April 1, 2025 -March 31, 2026**

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	\$6,000	\$9,500
Family	\$12,000	\$19,000
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
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
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

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
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
Professional Counselling Sessions 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
Psychiatric Medication Evaluation	\$15 copay (not subject to deductible)	40% after deductible
Applied Behavioral Analysis Therapy <sup>3</sup> Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis.	\$15 copay (not subject to deductible)	40% after deductible
Partial Hospitalization (PHP) <sup>3</sup> 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

Benefit	In-Network	Out-of-Network
	<i>(Coinsurance and Copays displayed are Employee responsibility)</i>	
Outpatient Detoxification 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
Intensive Outpatient Sessions (IOP) 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	<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>
ICUBAcares Pharmacist Advocate	(877) 286-3967	<a href="https://www.icubacares.org/">https://www.icubacares.org/</a>
Lantern	(855) 200-2099	<a href="https://my.lanterncare.com/">https://my.lanterncare.com/</a>
Virta	<a href="https://www.virtahealth.com/contact">https://www.virtahealth.com/contact</a>	<a href="https://www.virtahealth.com/join/icuba">https://www.virtahealth.com/join/icuba</a>
Hinge Health	(855) 902-2777	<a href="https://www.hingehealth.com/for/icuba/">https://www.hingehealth.com/for/icuba/</a>

# ATTENTION ICUBA MEMBERS

# ICUBA April 1, 2025 – March 31, 2026 Prescription Medication Plan

## ICUBA Pharmacy Benefit Prescription Plan Summary

### 30-Day Supply

#### Nationwide Pharmacy Network

You have access to more than 62,000 chain and independent pharmacies including: Costco, CVS, Publix Super Markets Inc., Walgreens, Target, The Medicine Shoppe, Walmart, Winn-Dixie Stores, Inc.

### 90-Day Supply

#### Convenient Mail Service Pharmacy

Home Delivery is an easy way to receive up to a 90-day supply of your maintenance medication delivered by mail to your door. Standard shipping is free. Orders are shipped in confidential, tamper-evident packaging from Home Delivery pharmacies.

### 90-Day at Retail Program

This program allows you to obtain a 90-day supply of your maintenance medication at more than 45,000 participating community pharmacies.

### Out-of-Pocket Maximum

In-network Rx copays will be applied toward an individual maximum out-of-pocket of \$2,000 and \$4,000 for family. Once you reach your out-of-pocket maximum, your prescriptions will be paid at 100% by the plan and no cost to you (\$0 copay).

### Diabetic Supplies

The following prescribed diabetic supplies are covered at 100%, \$0 copay: meters, lancets, lancing devices, test strips, control solution, insulin needles and syringes.

### Rx with Over-the-Counter (OTC) alternatives

The Rx with OTC strategy excludes certain prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

### Over-The-Counter and Generic Preventive Medications

With a prescription from your physician, the following OTC and generic preventive medications are covered as part of your pharmacy benefit with \$0 copay: Aspirin for adults, prenatal vitamins or folic acid for women planning or capable of pregnancy, iron supplementation, oral fluoride supplementation for children, vaccines, Vitamin D for adults, bowel preparation agents for colorectal cancer screening, and select statins for prevention of cardiovascular disease (CVD).

### Tobacco Cessation

Tobacco cessation medications are covered with \$0 copay when you participate in coaching or counseling options through local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling.

### Specialty Medications

Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Optum Specialty Pharmacy with BlueCross BlueShield.

### MyRx Toolkit and MyHealthToolkit

Find answers by visiting the **MyRx Toolkit** and **MyHealth Toolkit** through the single sign-on section at <http://ICUBAbenefits.org> to find your lowest copay, manage Home Delivery prescriptions, keep track of your health history and more!

### Care Connected in your Corner

If you have a question about your pharmacy benefit, call the Care Connected team toll-free at **(855) 258-9029**, 24 hours a day, 7 days a week.



If you have a question about your pharmacy benefit, and would like to speak with a Pharmacist at ICUBAcares, call **(877) 286-3967**.

Copayments	Prescription-Fill Methods*			
	Tier	Retail: Up to a 30-day supply	90-Day at Retail Program Up to a 90-day supply	Mail: Up to a 90-day supply
Low Cost Generics at the Nova Southeast University (NSU) Pharmacy		\$0	\$0	N/A
Low Cost Generics at all other network pharmacies		\$5	\$10	\$10
Preventive Generics****		\$0	\$0	\$0
Generics: Tier 1 Medications on the Premium Formulary (PF)**		\$10	\$20	\$20
Preferred Brands: Tier 2) Medications on the Premium Formulary		\$55	\$110	\$110
Non-Preferred Brands: Tier 3 Medications Premium Formulary		\$95	\$180	\$180
Preferred specialty at Optum Specialty Pharmacy***		20% coinsurance	N/A	N/A
Non-preferred specialty at Optum Specialty Pharmacy***		20% coinsurance	N/A	N/A

‡ 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.

\* 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.

\*\* The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

\*\*\* Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products. Coinsurance not to exceed \$500 per prescription, covered at 100% once pharmacy out-of-pocket maximum has been satisfied

\*\*\*\* 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)



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>\$6,000</b> in-network per person; <b>\$12,000</b> family/ <b>\$9,500</b> out-of-network per person/ <b>\$19,000</b> family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	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.

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



 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	<p>Additional cost shares may apply for physician administered drugs.</p> <p>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.</p> <p>Therapy and Chiropractic visits are limited to 60 each per Plan Year.</p> <p>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.</p>
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	\$0 Copayment/Visit	Not Applicable	
	Embold Health	\$0 Copayment/Visit	Not Covered	
	<u>Specialist</u> 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	

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.



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.
	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)	

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.



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; not to exceed \$500 per prescription	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	Prescribed preventive generic medications to treat 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; 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>	<a href="#">Emergency room care</a>	\$500 Copayment	\$500 Copayment	Waived if Admitted
	<a href="#">Emergency medical transportation</a>	\$250 Copayment	\$250 Copayment	None
	<a href="#">Urgent care</a>	\$30 Copayment/Visit	\$30 Copayment/Visit	None
	<a href="#">Teladoc Telemedicine</a>	\$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

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.





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>  For more information on Behavioral Health and Substance Abuse call: 1-800-868-1032	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>	<a href="#">Home health care</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	<a href="#">Rehabilitation services</a>	\$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.
	<a href="#">Habilitation services</a>	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior Authorization required
	<a href="#">Skilled nursing care</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Up to 60 visits per benefit period

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.



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="#">Durable medical equipment</a>	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization required
	<a href="#">Hospice services</a>	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:

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

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:**

<i>Cost Sharing</i>	
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:**

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

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

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



## 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.

# Your covered diabetes reversal\* benefit



## No fad diets or extra gym visits—just foods that are right for you

Virta is your guided nutrition program—available at **\$0 cost to you**. Personalized to your lifestyle and health goals, Virta uses nutrition science to build custom plans that help you lose weight, lower your blood sugar, and transform your health.

## Join the thousands of people using Virta and transforming their lives



“The most surprising thing about Virta is how much I enjoy my new way of eating. I’ve lost 30 pounds and have been able to maintain it, and my life no longer revolves around my diabetes meds.”

**Ricardo, Virta member**

## Virta is your fully-covered benefit for better health.

Get personalized nutrition support at no cost to you.

[Claim my benefit](#)

## At \$0 cost to you, you’ll receive:



Personalized health coaching



Connected weight scale and blood meter



Exclusive nutrition resources and recipes



Dedicated medical guidance



Visit [www.virtahealth.com/join/icuba](http://www.virtahealth.com/join/icuba) or scan the QR code to claim your benefit today.



Virta is available to ICUBA members and eligible dependents between the ages of 18 and 79. This benefit is currently being offered to those with type 2 diabetes. There are some medical conditions that would exclude patients from the Virta treatment. Start the application process now to find out if you qualify.

\*Reversal on Virta is defined by reaching an A1c below 6.5% without the use of diabetes medications beyond metformin. Diabetes and related issues can return if lifestyle changes are not maintained.



# Your covered weight loss benefit



**No fad diets or extra gym visits—just foods that are right for you** Virta is your guided nutrition program—available at **\$0 cost to you**. Personalized to your lifestyle and health goals, Virta uses nutrition science to build custom plans that help you sustainably lose weight and transform your health.

## Join the thousands of people using Virta and transforming their lives



"I FEEL wonderful. For the first time in my life, I am losing weight safely and eating real food. The plan is easy to follow, and the weight loss has been so surprising that I've had to buy new clothes already."

**Bob, Virta member**



Visit [virtahealth.com/join/optumrx](https://virtahealth.com/join/optumrx) or scan the QR code to claim your benefit today.

**Virta is your fully-covered benefit for better health.**

Get personalized nutrition support at no cost to you.

**At \$0 cost to you, you'll receive:**



Personalized health coaching



Connected weight scale



Exclusive nutrition resources and recipes



Dedicated medical guidance

Virta Health's nutrition therapy care plans may be suitable for adults (18+) with certain metabolic health conditions. For more information and to confirm eligibility, please visit: [www.virtahealth.com/join/optumrx](https://www.virtahealth.com/join/optumrx) and click 'Join Now' to start your application. Members were selected to receive this communication based on pharmacy claims data. Information in this letter is confidential and not shared with any non-medical personnel or personnel not directly managing pharmacy claims. Medications listed in this letter are subject to change. This document and others, if attached, contain information from Optum Rx that is proprietary, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to Optum Rx, PO Box 2749, Shawnee Mission, KS 66201

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación. 請注意: 如果您說中文, 我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼

All Optum® trademarks and logos are owned by Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are trademarks or registered marks of their respective owners. ©2024 Virta Health. All rights reserved.

