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, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.webtpa.com or call 1-888-632-3235 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 Individual /$1,200 Family when using Best Care Alliance providers. $500 Individual /$1,500 Family when using Blue Options PPO network providers. $750 Individual /$2,250 Family when using non-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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 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?	No.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	$2,500 Individual/ $7,500 Family when using Best Care Alliance providers. $5,000 Individual/$15,000 Family when using Blue Options PPO network providers. $10,000 Individual /$30,000 Family when using non-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, URC services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. If you reside in Lee County, or within 50 miles, use the BCA network. See https://bestcarealliance.org/ or call 239-343-1844 for a list of network providers. If you reside 50 miles or more outside of Lee County, use the Blue Options PPO network https://www.flbluegroupbenefits.com/. Benefits will be allowed the same as the preferred tier if the provider is	You pay the least if you use a provider in Best Care Alliance network. You pay more if you use a provider in Blue Options PPO network. If you reside 50 miles or more outside Lee County and use the Blue Options PPO network, you will receive benefits at the preferred benefit level provided the provider is also outside of Lee County and in the Blue Options PPO 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).

Important Questions	Answers	Why This Matters:
	also outside of Lee County and in the Blue Options PPO network.	Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	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	$25 copayment	25% coinsurance	50% coinsurance	——————None——————
	Specialist visit	$50 copayment	25% coinsurance	50% coinsurance	——————None——————
	Preventive care/screening/ immunization	No charge	25% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copayment No charge for labs	25% coinsurance	50% coinsurance	——————None——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance	50% coinsurance	Must be done at LH if employee resides in Lee County.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at LH Retail Pharmacies at 239-343-2800 for Lee Health and 239-343-5100 for Health Park and Capital RX network of Retail Pharmacies at 1-833-599-0978, www.cap-rx.com.or Mail Order Pharmacy at 1-239-424-3197.	Generic drugs (Tier 1)	$10 copayment/per prescription for 30-day supply; $15 copayment/per prescription for 31-60 days. $20 copayment/per prescription 61-90 days Mail Order-up to 90-day fills. $10 copayment/per prescription	$15 copayment/per prescription for 30-day supply; at Capital RX retail pharmacy. $20 copayment/per prescription for 31–60-day supply. $25 copayment/per prescription for 61–90-day supply	Not Covered	Must use LH retail pharmacies, Capital RX's network of retail pharmacies such as Walgreens and Publix Pharmacies for up to a 30-day supply and LH Mail Order Pharmacy for a 31-90 day supply. Otherwise, no coverage.
	Preferred brand drugs (Tier 2)	$30 copayment/per prescription for 30-day supply; $45 copayment/per prescription for 31-60 days. $60 copayment/per prescription 61-90 days	$35 copayment/per prescription for 30-day supply at Capital RX retail pharmacy. $50 copayment/per prescription for 31–60-day supply.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	Out-of-Network Provider (You will pay the most)	
		Mail Order-up to 90-day fills. $50 copayment/per prescription	$65 copayment/per prescription for 61–90-day supply		
	Non-preferred brand drugs (Tier 3)	$60 copayment/per prescription for 30-day supply; $90 copayment/per prescription for 31-60 days. $120 copayment/per prescription 61-90 days Mail Order-up to 90-day fills. $100 copayment/per prescription	$65 copayment/per prescription for 30-day supply at Capital RX retail pharmacy. $95 copayment/per prescription for 31–60-day supply. $125 copayment per prescription for 61–90-day supply	Not Covered	
	Specialty drugs (Tier 4) Preferred Specialty (Tier 5) Non-Preferred Specialty	Up to 30-day supply $150 copayment $250 copayment	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	50% coinsurance	Some procedures may require precertification.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	50% coinsurance	——————None——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility-$150 copayment and 10% coinsurance ER Physician $50 copayment and 10% coinsurance	Facility-$150 copayment and 10% coinsurance ER Physician $50 copayment and 10% coinsurance	Facility-$150 copayment and 10% coinsurance ER Physician $50 copayment and 10% coinsurance	$50 copayment applies to ER Physician visit. All other ancillary providers/services are 10% coinsurance.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	No Network Service Available Not covered unless emergency
	Urgent care	$35 copayment	25% coinsurance	50% coinsurance	The copayment includes all services rendered in the physician's office on the same day, except for x-rays.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment / day a maximum of $500 per admission	25% coinsurance	50% coinsurance	Readmission within 7 days after discharge, for the same condition, has no additional co-pay. Must get preauthorization from Web-TPA at 1-888-632-3235. Otherwise, no coverage.
	Physician/surgeon fees	$25 copayment PCP $50 copayment Specialist	25% coinsurance	50% coinsurance	The PCP or Specialist copayment will be applied once per specialty type and only once per admission.
If you need mental health, behavioral health,	Outpatient services	$25 copayment per office visit 10% coinsurance for other services	25% coinsurance	50% coinsurance	——————None——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	Out-of-Network Provider (You will pay the most)	
or substance abuse services	Inpatient services	$100 copayment per day maximum of $500 per admission	25% coinsurance	50% coinsurance	Must get preauthorization from Web-TPA at 1-888-632-3235. Otherwise, no coverage.
If you are pregnant	Office visits	$25 copayment for first visit	25% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance , or deductible may apply. Maternity care
	Childbirth/delivery professional services	$350 copayment	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$100 copayment per day maximum of $500 per admission	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$25 copayment per visit	25% coinsurance	50% coinsurance	Limit 20 visits per year/40 hours per week
	Rehabilitation services	First 12 visits no charges thereafter 10% coinsurance	25% coinsurance	50% coinsurance	Non-BCA & Wrap must be authorized for benefits to be applied. Cardiac Rehab max of 36 visits.
	Habilitation services	First 12 visits no charges thereafter 10% coinsurance	25% coinsurance	50% coinsurance	——————None——————
	Skilled nursing care	$100 copayment per day maximum of $500 per admission	25% coinsurance	50% coinsurance	Must get pre-authorization from Web-TPA at 1-888-632-3235; Otherwise, no coverage.180-day calendar year maximum.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BCA Network (You will pay the least)	Blue Options Provider	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	10% coinsurance	25% coinsurance	50% coinsurance	Must use Access Medical South and approved vendors for purchases. Amounts over $500 must be pre-authorized by Web-TPA at 1-888-632-3235. Out-of-network purchases require pre-authorization too. Otherwise, no coverage.
	Hospice services	No Charge	25% coinsurance	50% coinsurance	Must get preauthorization from Web-TPA at 1-888-632-3235. Otherwise, no coverage. Limited to 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	See the LH Vision Plan
	Children's glasses	Not Covered	Not Covered	Not Covered	See the LH Vision Plan
	Children's dental check-up	Not Covered	Not Covered	Not Covered	See the LH Dental Plan

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, message & herbal therapy
- Cosmetic surgery
- Dental Care – routine adult
- Eye care – routine
- Foot care – routine
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Allergy & Asthma treatments
- Bariatric surgery (lap band & gastric sleeve only)
- Chiropractic care
- Hearing Aids
- Smoking Cessation (limited benefit)
- Weight Loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-632-3235.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-632-3235.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-632-3235.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-632-3235.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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	$400
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,060**

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

The plan's overall deductible	**$400**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$500
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

The plan would be responsible for the other costs of these EXAMPLE covered services.