

TGH Imaging OOA HSA

Coverage For: Individual + Family Plan Type: HDHP



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-594-6012 or visit us at FL.ExploreMyPlan.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance after overall deductible](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-844-594-6012 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$5,000 / individual or \$10,000 / family in-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive services in-network are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance after overall deductible may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Preventive services in-network are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance 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/ .
What is the out-of-pocket limit for this plan ?	For in-network \$7,000 individual/\$15,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limit 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 and healthcare this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See FL.ExploreMyPlan.com or call 1-800-810-BLUE for a list of network providers .	This plan uses a provider network. You will pay less if you use a provider in the plan 's network. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance after overall deductible](#) costs shown in this chart are after overall your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	Precertification is required for some provider administered drugs; if no precertification is obtained; 50% penalty may apply
	Specialist visit	20% coinsurance	Not covered	
	Preventive care/screening/immunization	No Charge Deductible does not apply	Not covered	Please visit FL.ExploreMyPlan.com/FLPreventiveServices ; You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Benefits listed are physician services ; facility benefits are also available; precertification may be required; if no precertification is obtained; 50% penalty may apply
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition	Tier 1 Drugs	25% with a minimum of \$60 and a maximum of \$150 (retail) \$30 copay (mail order)	Not Covered	Precertification is required for some drugs; if no precertification is obtained, no benefits are available; additional benefits for a 90-day supply
	Tier 2 Drugs	35% with a minimum of \$80 and a maximum of \$300 (retail) \$40 copay (mail order)	Not Covered	
	Tier 3 Drugs	35% with a minimum of \$100 and a maximum of \$400 (retail) \$50 copay (mail order)	Not Covered	
	Tier 4 Drugs	\$120 copay (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Precertification may be required; if no precertification is obtained; 50% penalty may apply
	Physician/surgeon fees	20% coinsurance	Not covered	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Accident: \$500 copay /visit & 20% coinsurance Medical Emergency: \$500 copay /visit & 20% coinsurance	Accident: \$500 copay /visit & 20% coinsurance Medical Emergency: \$500 copay /visit & 20% coinsurance	Physician charges will apply; out-of-network non-emergent visits not covered; copay waived if admitted as inpatient within 24 hours
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-true emergency ambulance not covered
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Precertification is required; if no precertification is obtained; 50% penalty may apply
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained; 50% penalty may apply
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); precertification may be required for some inpatient services; if no precertification is obtained; 50% penalty may apply
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to combined maximum of 100 visits per calendar year; benefits are also available for home infusion services; precertification may be required; if no precertification is obtained; 50% penalty may apply
	Rehabilitation services	20% coinsurance	Not covered	Limited to combined maximum of 40 visits per calendar year for occupational and physical therapy; speech therapy limited to a maximum of 40 visits per calendar year; no age or visit limits for occupational, physical and speech therapy for autism spectrum disorders
	Skilled nursing care	20% coinsurance	Not covered	Limited to 120 days per calendar year; precertification is required; if no precertification is obtained; 50% penalty may apply
	Durable medical equipment	20% coinsurance	Not covered	Precertification may be required; if no precertification is obtained; 50% penalty may apply
	Hospice services	20% coinsurance	Not covered	Precertification may be required; if no precertification is obtained; 50% penalty may apply
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not Covered	Limitations apply
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not Covered	Not Covered	Not covered; member pays 100%

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

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 .)		
<ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)• Routine foot care	<ul style="list-style-type: none">• Dental check-up, child• Habilitation services• Long-term care	<ul style="list-style-type: none">• Private-duty nursing• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture (Limitations apply)• Bariatric surgery• Chiropractic care (limited to a maximum of 40 visits per calendar year)	<ul style="list-style-type: none">• Infertility treatment (Assisted Reproductive Technology not covered)• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Routine eye care (Adult)• Hearing Aids (Limitations apply)

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or your [plan](#) administrator at the phone number listed in your benefit booklet. 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: Your [plan](#) administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

Does this [plan](#) provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other copayment/coinsurance	\$500/35%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other copayment/coinsurance	\$500/35%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$5,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other copayment/coinsurance	\$500/35%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [FL.ExploreMyPlan.com](#).