

Academic Medical Group (HSA) 90963

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 1-833-708-2308 or visit us at FL.ExploreMyPlan.com. 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.cciio.cms.gov or call 1-833-708-2308 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Domestic Network (Tier 1): \$3,400 Individual/\$6,600 Family; Select Providers (Tier 2): \$3,400 Individual/\$6,600 Family; BlueOptions (Tier 3): \$5,000 Individual/\$12,000 Family Out-of-Network (Tier 4): \$10,000 Individual/\$25,000 Family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive services in-network are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductible for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Domestic Network (Tier 1): \$3,400 Individual/\$6,600 Family; Select Providers (Tier 2): \$4,200 Individual/\$8,400 Family; BlueOptions (Tier 3): \$6,750 Individual/\$13,500 Family; Out-of-Network (Tier 4): \$12,750 Individual/\$25,500 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges and healthcare this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See FL.ExploreMyPlan.com or call 1-800-810-BLUE for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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
		Tier 1 Domestic Network (You will pay the least)	Tier 2 Select Provider (You will pay the most)	Tier 3 BlueOptions (You will pay the most)	Tier 4 Out-of-Network (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	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Precertification is required for some provider administered drugs; if no precertification is obtained; no benefits are available 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.
	Specialist visit	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	
	Preventive care/screening/immunization	No Charge Deductible does not apply	No Charge Deductible does not apply	No Charge Deductible does not apply	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Benefits listed are physician services ; facility benefits are also available; precertification may be required; if no precertification is obtained; no benefits are available
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	

* 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
		Tier 1 Domestic Network (You will pay the least)	Tier 2 Select Provider (You will pay the most)	Tier 3 BlueOptions (You will pay the most)	Tier 4 Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at FL.ExploreMyPlan.com/druglist	Tier 1 Drugs	30% coinsurance (retail) \$30 copay (mail order)	30% coinsurance (retail) \$30 copay (mail order)	30% coinsurance (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 90-day supply
	Tier 2 Drugs	30% coinsurance (retail) \$40 copay (mail order)	30% coinsurance (retail) \$40 copay (mail order)	30% coinsurance (retail) \$40 copay (mail order)	Not covered	
	Tier 3 Drugs	30% coinsurance (retail) \$50 copay (mail order)	30% coinsurance (retail) \$50 copay (mail order)	30% coinsurance (retail) \$50 copay (mail order)	Not covered	
	Tier 4 Drugs	30% coinsurance (specialty)	30% coinsurance (specialty)	30% coinsurance (specialty)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	10% coinsurance	30% coinsurance	50% coinsurance	Precertification may be required; if no precertification is obtained; no benefits are available
	Physician/surgeon fees	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Physician charges will apply; subject to in-network overall deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	Subject to in-network overall deductible
	Urgent care	30% coinsurance	30% coinsurance	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	10% coinsurance	30% coinsurance	50% coinsurance	Precertification is required; if no precertification is obtained; no benefits are available
	Physician/surgeon fees	100% coinsurance	90% coinsurance	30% coinsurance	50% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Domestic Network (You will pay the least)	Tier 2 Select Provider (You will pay the most)	Tier 3 BlueOptions (You will pay the most)	Tier 4 Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained; no benefits are available
	Inpatient services	0% coinsurance	10% coinsurance	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	<p>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; no benefits are available</p>
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	10% coinsurance	30% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Domestic Network (You will pay the least)	Tier 2 Select Provider (You will pay the most)	Tier 3 BlueOptions (You will pay the most)	Tier 4 Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Limited to combined maximum of 60 visits per member per calendar year; benefits are also available for home infusion services; precertification may be required; if no precertification is obtained; no benefits are available
	Rehabilitation services	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Limited to combined maximum of 20 visits per member per calendar year for occupational and physical therapy; limited to a maximum of 20 visits per member per calendar year for speech therapy; no age or visit limits for occupational, physical and speech therapy for autism spectrum disorders
	Skilled nursing care	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Maximum benefit 60 days per member per calendar year; precertification is required; if no precertification is obtained; no benefits are available
	Durable medical equipment	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Precertification may be required; if no precertification is obtained; no benefits are available

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Domestic Network (You will pay the least)	Tier 2 Select Provider (You will pay the most)	Tier 3 BlueOptions (You will pay the most)	Tier 4 Out-of-Network (You will pay the most)	
	Hospice services	0% coinsurance	0% coinsurance	30% coinsurance	50% coinsurance	Precertification may be required; if no precertification is obtained; no benefits are available
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered; member pays 100%
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered; member pays 100%
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	Not covered; member pays 100%

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Dental check-up, child • Long-term care • Acupuncture 	<ul style="list-style-type: none"> • Routine foot care • Private-duty nursing • Routine eye care (Adult) • 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"> • Bariatric surgery (only for morbid obesity in limited circumstances) • Chiropractic care (Limited to maximum of 20 visits per calendar year) 	<ul style="list-style-type: none"> • Infertility treatment (limitations apply) • Non-emergency care when traveling outside the U.S. 	

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.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [provider's](#) 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	\$3,400	■ The plan's overall deductible	\$3,400	■ The plan's overall deductible	\$3,400
■ Specialist coinsurance	0%	■ Specialist coinsurance	0%	■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%
■ Other coinsurance	30%	■ Other coinsurance	30%	■ Other coinsurance	30%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$3,400	Deductibles	\$3,400	Deductibles	\$2,800
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
The total Peg would pay is	\$3,460	The total Joe would pay is	\$3,440	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.