

Academic Medical Group 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 1-833-708-2308 or visit us at [FL.ExploreMyPlan.com](http://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](http://www.cciio.cms.gov) or call 1-833-708-2308 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,000 / individual or \$12,000 / family in-network. \$10,000 / individual or \$24,000 / family out-of-network.	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> in-network are covered before you meet your <a href="#">deductible</a> .	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 after overall deductible</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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <a href="#">Preventive services</a> in-network are covered before you meet your <a href="#">deductible</a> .	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> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For in-network \$6,750 individual/\$13,500 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges and healthcare this <a href="#">plan</a> doesn't cover, <a href="#">cost sharing</a> for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://FL.ExploreMyPlan.com">FL.ExploreMyPlan.com</a> or call 1-800-810-BLUE for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's network. 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 <a href="#">provider's</a> 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	Not covered	Precertification is required for some <a href="#">provider</a> administered drugs; if no precertification is obtained; no benefits are available  Please visit <a href="http://FL.ExploreMyPlan.com/FLPreventiveServices">FL.ExploreMyPlan.com/FLPreventiveServices</a> ; You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	Benefits listed are <a href="#">physician services</a> ; facility benefits are also available; precertification may be required; if no precertification is obtained; no benefits are available
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need drugs to treat your illness or condition</b>	Tier 1 Drugs	30% <a href="#">coinsurance</a> (retail) \$30 <a href="#">copay</a> (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	30% <a href="#">coinsurance</a> (retail) \$40 <a href="#">copay</a> (mail order)	Not Covered	
	Tier 3 Drugs	30% <a href="#">coinsurance</a> (retail) \$50 <a href="#">copay</a> (mail order)	Not Covered	
	Tier 4 Drugs	30% <a href="#">coinsurance</a> (retail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Not covered	Precertification may be required; if no precertification is obtained; no benefits are available
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Accident: 30% <a href="#">coinsurance</a> Medical Emergency: 30% <a href="#">coinsurance</a>	Accident: 30% <a href="#">coinsurance</a> Medical Emergency: 30% <a href="#">coinsurance</a>	Physician charges will apply; out-of-network non-emergent visits not covered; subject to in-network overall <a href="#">deductible</a>
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to in-network overall <a href="#">deductible</a> ; non-true emergency ambulance not covered
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	Not covered	Precertification is required; if no precertification is obtained; no benefits are available
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [FL.ExploreMyPlan.com](http://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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <a href="#">coinsurance</a>	Not covered	Precertification is required for intensive outpatient, partial <a href="#">hospitalization</a> and inpatient <a href="#">hospitalization</a> ; if no precertification is obtained; no benefits are available
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	
<b>If you are pregnant</b>	Office visits	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> 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
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	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; no benefits are available
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	Limited to combined maximum of 80 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
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	Limited to 120 days per calendar year; precertification is required; if no precertification is obtained; no benefits are available
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	Precertification may be required; if no precertification is obtained; no benefits are available
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	Precertification may be required; if no precertification is obtained; no benefits are available
<b>If your child needs dental or eye care</b>	Children's eye exam	30% <a href="#">coinsurance</a>	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 <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>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Routine foot care</li></ul>	<ul style="list-style-type: none"><li>• Dental check-up, child</li><li>• Habilitation services</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Weight loss programs</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>• Acupuncture (Limitations apply)</li><li>• Bariatric surgery</li><li>• Chiropractic care (limited to a maximum of 40 visits per calendar year)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment (Assisted Reproductive Technology not covered)</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Hearing Aids (Limitations apply)</li></ul>

**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](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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,750
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,810</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">copayment/coinsurance</a>	30%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$5,140</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">copayment/coinsurance</a>	30%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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](#).