TGH Imaging OOA HSA

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, pre-certification and 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) 25% with a minimum of $60 and a maximum of $150 (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) 35% with a minimum of $80 and a maximum of $300 (mail order)	Not Covered	
	Tier 3 Drugs	35% with a minimum of $100 and a maximum of $400 (retail) 35% with a minimum of $100 and a maximum of $400 (mail order)	Not Covered	
	Tier 4 Drugs	$120 copay (retail)	Not Covered	

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 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
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	

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%

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.)

- Cosmetic surgery
- Dental care (Adult)
- Routine foot care
- Dental check-up, child
- Habilitation services
- Long-term care
- 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.)

- Acupuncture (Limitations apply)
- Bariatric surgery
- Chiropractic care (limited to a maximum of 40 visits per calendar year)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.
- 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.

* 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 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**

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**

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**

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: FI.ExploreMyPlan.com.

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