Florida Health Sciences Center, Inc. dba Tampa General Hospital (POS)

Coverage For: Individual + Family **Plan Type:** PPO

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, 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?	TGH Advantage (Tier 1): $0 Individual/$0 Family; Select Providers (Tier 2): $0 Individual/$0 Family; BlueOptions (Tier 3): $1,000 Individual/$2,000 Family Out-of-Network (Tier 4): $2,500 Individual/$5,000 Family	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, the overall family deductible must be met before the plan begins to pay.
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 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.	You don't have to meet deductible for specific services.
What is the out–of–pocket limit for this plan?	TGH Advantage (Tier 1): $1,500 Individual/$3,000 Family; Select Providers (Tier 2): $2,500 Individual/$5,000 Family; BlueOptions (Tier 3): $5,000 Individual/$10,000 Family; Out-of-Network (Tier 4): $10,000 Individual/$20,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care 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** 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 TGH Advantage (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	$10 copay/visit No overall deductible	$10 copay/visit No overall deductible	$30 copay/visit No overall deductible	50% coinsurance after overall deductible	None
	Specialist visit	$25 copay/visit No overall deductible	$25 copay/visit No overall deductible	$45 copay/visit No overall deductible	50% coinsurance after overall deductible	
	Preventive care/screening/ immunization	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	50% coinsurance after overall deductible	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)	No Charge No overall deductible	**Lab work:** No Charge No overall deductible **X-ray:** $25 copay/visit No overall deductible	**Lab work:** No Charge No overall deductible **X-ray:** $50 copay/visit No overall deductible	50% coinsurance after overall deductible	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	$50 copay/visit No overall deductible	$300 copay/visit No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 TGH Advantage (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	$45 copay (retail) $10 copay per prescription (In-House) No overall deductible	$45 copay (retail) $10 copay per prescription (In-House) No overall deductible	$45 copay (retail) $10 copay per prescription (In-House) No overall deductible	50% coinsurance after Tier 4 overall deductible	Prior authorization required for specific drugs; Additional benefits for 90-day supply; The only in-network pharmacies for drugs over $400 are Tampa General and any pharmacy referred by Tampa General
	Tier 2 Drugs	25% with a minimum of $60 and a maximum of $150 (retail) $15 copay per prescription (In-House) No overall deductible	25% with a minimum of $60 and a maximum of $150 (retail) $15 copay per prescription (In-House) No overall deductible	25% with a minimum of $60 and a maximum of $150 (retail) $15 copay per prescription (In-House) No overall deductible	50% coinsurance after Tier 4 overall deductible	
	Tier 3 Drugs	35% with a minimum of $80 and a maximum of $300 (retail) $20 copay per prescription (In-House) No overall deductible	35% with a minimum of $80 and a maximum of $300 (retail) $20 copay per prescription (In-House) No overall deductible	35% with a minimum of $80 and a maximum of $300 (retail) $20 copay per prescription (In-House) No overall deductible	50% coinsurance after Tier 4 overall deductible	
	Tier 4 Drugs	35% with a minimum of $100 and a maximum of $400 (specialty) $80 copay per prescription (In-House) No overall deductible	35% with a minimum of $100 and a maximum of $400 (specialty) $80 copay per prescription (In-House) No overall deductible	35% with a minimum of $100 and a maximum of $400 (specialty) $80 copay per prescription (In-House) No overall deductible	50% coinsurance after Tier 4 overall deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay No overall deductible	$500 copay No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	None
	Physician/surgeon fees	No Charge No overall deductible	No Charge No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	None
If you need immediate medical attention	Emergency room care	Accident: $250 copay/visit No overall deductible Medical Emergency: $250 copay/visit No overall deductible	Accident: $250 copay/visit No overall deductible Medical Emergency: $250 copay/visit No overall deductible	Accident: $250 copay/visit No overall deductible Medical Emergency: $250 copay/visit No overall deductible	Accident: $250 copay/visit No overall deductible Medical Emergency: $250 copay/visit No overall deductible	Physician charges will apply; Copay waived if admitted as inpatient within 24 hours

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 TGH Advantage (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)	
	Emergency medical transportation	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	Non-true emergency ambulance not covered; Transfers to Tier 1 or Tier 2 facility are covered
	Urgent care	$30 copay/visit No overall deductible	$50 copay/visit No overall deductible	$50 copay/visit No overall deductible	50% coinsurance after overall deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per admission No overall deductible	$1,000 copay per admission No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	Precertification is required
	Physician/surgeon fees	No Charge No overall deductible	No Charge No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	Inpatient Emergency Room Admission for Tier 2, 3, 4 pays at Tier 1 Benefit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit No overall deductible	$10 copay/visit No overall deductible	$10 copay/visit No overall deductible	50% coinsurance after overall deductible	Benefits listed are physician services; additional benefits are available; may require higher patient responsibility; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	No Charge No overall deductible	No Charge No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	
If you are pregnant	Office visits	No Charge No overall deductible	No Charge No overall deductible	No Charge No overall deductible	50% coinsurance after overall deductible	Cost sharing does not apply for certain 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)
	Childbirth/delivery professional services	$250 copay per admission No overall deductible	$250 copay per admission No overall deductible	$250 copay per admission No overall deductible	50% coinsurance after overall deductible	
	Childbirth/delivery facility services	$250 copay per admission No overall deductible	$1,000 copay per admission No overall deductible	40% coinsurance after overall deductible	50% coinsurance after overall deductible	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 TGH Advantage (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	10% coinsurance No overall deductible	10% coinsurance No overall deductible	10% coinsurance No overall deductible	50% coinsurance after overall deductible	Limited to combined maximum of 100 visits per calendar year; benefits are also available for home infusion services
	Rehabilitation services	$10 copay/visit No overall deductible	$20 copay/visit No overall deductible	$30 copay/visit No overall deductible	50% coinsurance after overall deductible	Limited to combined maximum of 80 visits per calendar year for Tier 1 and 2 occupational and physical therapy; Limited to a maximum of 40 visits per calendar year for speech therapy; medical necessity will be reviewed once Tiers 1 and 2 maximum is met; no benefits allowed for Tier 3 after 40 visits; no age or visit limits for occupational, physical and speech therapy for autism spectrum disorders
	Habilitation services	Not Covered	Not Covered	Not Covered	Not Covered	Not covered; members pays 100%
	Skilled nursing care	10% coinsurance No overall deductible	10% coinsurance No overall deductible	10% coinsurance No overall deductible	50% coinsurance after overall deductible	Maximum benefit 120 days per calendar year
	Durable medical equipment	10% coinsurance No overall deductible	10% coinsurance No overall deductible	10% coinsurance No overall deductible	50% coinsurance after overall deductible	None
	Hospice services	10% coinsurance No overall deductible	10% coinsurance No overall deductible	10% coinsurance No overall deductible	50% coinsurance after overall deductible	None
If your child needs dental or eye care	Children's eye exam	$25 copay/visit No overall deductible	$25 copay/visit No overall deductible	$45 copay/visit No overall deductible	Not covered	Limitations apply
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Habilitation services
- Long-term care
- Routine foot 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 (only for morbid obesity in limited circumstances)
- Chiropractic care (Limited to maximum of 40 visits per calendar year)
- Hearing aids (Limitations Apply)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (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 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 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 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 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)

The plan's overall deductible	$0
Specialist copay/coinsurance	$25/0%
Hospital (facility) copay/coinsurance	$250/0%
Other copay/coinsurance	$250/25%

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	$260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$320

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

The plan's overall deductible	$0
Specialist copay/coinsurance	$25/0%
Hospital (facility) copay/coinsurance	$200/0%
Other copay/coinsurance	$200/20%

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	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,040

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

The plan's overall deductible	$0
Specialist copay/coinsurance	$25/0%
Hospital (facility) copay/coinsurance	$200/0%
Other copay/coinsurance	$200/20%

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	$0
Copayments	$350
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$370

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.