Florida Blue **Bloomin Brands : Choice HSA - EE+Family**

This 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 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 **833-578-1132.** 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 **https://www.healthcare.gov/sbc-glossary** or **www.cciio.cms.gov** or call **833-578-1132** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$4,000** person/**$8,000** family. Out-of-Network **$7,500** person/**$15,000** family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care services 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 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network **$10,600** person/**$13,000** family. Out-of-Network **$15,000** person/**$45,000** 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 limits 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 health care this plan doesn't cover.	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 **www.MyHealthToolkitFL.com** or call **1-800-810-BLUE (2583)** 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
		In-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	50% Coinsurance	Teladoc visits are covered.
	Specialist visit	20% Coinsurance	50% Coinsurance	Teladoc dermatology and nutrition visits are covered.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. 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	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.express-scripts.com/login	Generic drugs (Retail)	20% Coinsurance	20% Coinsurance	Certain drugs may require step therapy and/or preauthorization. Maintenance prescriptions must be filled in 90-day supplies through Express Scripts Pharmacy (home delivery) or a Smart90 network retail pharmacy.
	Generic drugs (Mail Order)	20% Coinsurance	20% Coinsurance	Certain drugs may require step therapy and/or preauthorization
	Preferred brand drugs (Retail)	20% Coinsurance	20% Coinsurance	Certain drugs may require step therapy and/or preauthorization. Maintenance prescriptions must be filled in 90-day supplies through Express Scripts Pharmacy (home delivery) or a Smart90 network retail pharmacy.
	Preferred brand drugs (Mail Order)	20% Coinsurance	20% Coinsurance	Certain drugs may require step therapy and/or preauthorization
	Non-preferred brand drugs (Retail)	40% Coinsurance	40% Coinsurance	Certain drugs may require step therapy and/or preauthorization. Maintenance prescriptions must be filled in 90-day supplies through Express Scripts Pharmacy (home delivery) or a Smart90 network retail pharmacy.
	Non-preferred brand drugs (Mail Order)	40% Coinsurance	40% Coinsurance	Certain drugs may require step therapy and/or preauthorization
	Specialty drugs	20-40% Coinsurance	20-40% Coinsurance	Based on retail tier; contact Accredo specialty pharmacy

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	50% Coinsurance	Varicose vein treatments are limited to $2,500/benefit year.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$300 Copay/ visit	$300 Copay/ visit	Copayment will be waived if admitted.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge Out-of-Network.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	20% Coinsurance	50% Coinsurance	Teladoc behavioral health visits are covered.
	Substance use disorder outpatient services	20% Coinsurance	50% Coinsurance	
	Mental/behavioral health inpatient services	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge Out-of-Network.
	Substance use disorder inpatient services	20% Coinsurance	50% Coinsurance	
If you are pregnant	Office visits	20% Coinsurance	50% Coinsurance	Pre-authorization for facility services is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge Out-of-Network. Depending on the type of services, a coinsurance or deductible may apply. Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Rehabilitation services	20% Coinsurance	50% Coinsurance	30 visits/benefit year each for Occupational Therapy, Physical Therapy and Speech Therapy
	Habilitation services	20% Coinsurance	50% Coinsurance	30 visits/benefit year each for Occupational Therapy, Physical Therapy and Speech Therapy
	Skilled nursing care	20% Coinsurance	50% Coinsurance	120 days/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization is 50% of the allowable charge Out-of-Network.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Purchase or rentals of $1,000 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges. Hearing aids are limited to $2,500/ear, every three years. Wigs are limited to 3 units/benefit year, up to $500.
	Hospice services	20% Coinsurance	50% Coinsurance	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges for In-Network outpatient and all Out-of-Network services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See your Employer for benefit details.
	Children's glasses	Not Covered	Not Covered	See your Employer for benefit details.
	Children's dental check-up	Not Covered	Not Covered	See your Employer for benefit details.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery, one surgery/lifetime
- Chiropractic Care, 30 visits/benefit year
- Hearing Aids
- Infertility Treatment, diagnosis/testing/treatment of underlying condition
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing, if part of pre-authorized home health care

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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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: 833-578-1132 or visit us at www.MyHealthToolkitFL.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/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 page.*———————————

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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 (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** **$4,000**
- **Specialist Coinsurance** **20%**
- **Hospital (facility) Coinsurance** **20%**
- **Other Coinsurance** **20%**

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	$4,000
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$5,770**

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

- **The plan's overall deductible** **$4,000**
- **Specialist Coinsurance** **20%**
- **Hospital (facility) Coinsurance** **20%**
- **Other Coinsurance** **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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$5,400**

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

- **The plan's overall deductible** **$4,000**
- **Specialist Coinsurance** **20%**
- **Hospital (facility) Coinsurance** **20%**
- **Other Coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,710**

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:**833-578-1132.**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TIY: 711) or speak to your provider.

Espanol: ATENCION: Si habla espafiol, tiene a su disposici6n servicios gratuitos de asistencia lingufstica. Tambien estan disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar informaci6n en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

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Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Portugues do Brasil: ATEN<;::A.O: Se voce fala portugues, ha servi9os gratuitos de assistencia linguistica disponiveis para voce. Assistencia e servi9os auxiliares pr6prios para fomecer informa96es em formatos acessiveis tambem estao disponiveis gratuitamente. Ligue para 1-844-396-0182 (TIY: 711) ou fale com seu provedor. (Portuguese)

Fran9ais : NOTE : Si vous parlez fran9ais, des services gratuits d'assistance linguistique sont it votre disposition. Des aides et des services auxiliaires appropries pouvant foumir des informations dans des formats accessibles sont egalement disponibles gratuitement. Appelez le 1-844-396-0190 (TTY: 711) ou adressez-vous it votre prestataire. (French)

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Deutsch: ACHTIJNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfugung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfugung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Iluem Anbieter. (German)

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Kiswahili MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo iii kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

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Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsasaoka iti llocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenno makisarita iti mangipapaay kenka. (llocano)

□mcrm: □c1q1$o-l%•"1llTTlfl cil□i>vlt\□ □.-lc1ql$cfil □c;.=r:□IMi □ □ □ □iYo,Iggil<l1•<l i':.lillt\□J-ll □ □o-1.-1.3q<Jcfc1 □ □ □qc;..:rc;f.=t:□IMi□iYo,I1-844-465-1722 (TTY: 711)m q;)..,□ 3TTtFo-IT□, TT□I (Nepali)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sano inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1'1-844-396-0184 (TTY: 711) o parla con ii tuo fornitore. (Italian)

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Kreyol Ayisyen ATANSYON: Si w pale Kreyol Ayisyen, gen sevis ed aladispozisyon w gratis pou lang au pale a. Ed ak sevis siplemante apwopriye pou bay enfomasyon nan foma aksesib yo disponib gratis tau. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avek founise w la. (Haitian Creole)

POLSKI UWAGA: Osoby m6wiqce po polsku mogq skorzystac z bezplatnej pomocy j□zykowej. Dodatkowe pomoce i ustugi zapewniajqce informacje w dost□pnych formatach Sq r6wniei dost□pne bezplatnie. Zadzwon pod numer 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcq. (Polish)

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Lus Hmoob

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov horn ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

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171nnt§l□HWnG\;)□nt:11Ai LUwstu□nstmw l'flhfll?JU11nn1c1\::l§Wffinni"lnf'intj;jii'lHi SnJLHiU□n□ c;§W s□tn1nn1c1t't:1rm::l1ffi11i'!W□nJH1HJ !;')□ffil\:'!runf'iHi SffiHSLH8tt:1ruH1ugrutLuu:;1we;, s AH1G1nC1stt:11Wi"lnf'int□Ci□tt:11□ tUTi□lnJl]tsi 1-844-465-1721 (TTY: 711) ystmwtsiffiS□n1:'!rutn1f11Ut\J□n□ (Khmer)

\r'..Jt_; oy,. o.l1>,.>',.\..)\ I., L, ,,□ <Y'w (711 :'-;-':!i.:;.J:;) 1-844-398-6233 ,)....& I., _,;.t4s-- oy,.y, uK,1..) ..)_,kl, •(Y'y.u,.l J,L! <.SlA,ylL, ._JJ w□)Lb\ "-'U <.SIY. '-,-WW.. i..."4- wl...wi. J IA,□□ .J._J\J J) W (Y'y.u,.l ._JJ ul,j cs'□uK,1..) wl...wi. "'As'□i.r'..Jt_; .},I :<4y (Farsi).□□

y) (Urdu) -u,J, wl, c •□r1I.J c:?-i L, u,_f, JS✓.: (1-844-465-1725 TIY: 711)-u:!i yi_,:;...., wi.o <.#. c:,t....;,. ..JJI ob..\ uJ1,.,, '-,-Wu.. d cf, c:?J. r1I.J wt.._,1...oY..A □...Jt.; i.s'w..J J,L! .U:!/ yl,,.uu c:,t....;,. c,Su□I <.s'l..u,] wi.o d cf,'-;-'l y 'U:!i c"Y. _,o) '71.J,1 :u,o□Y

ill'I'□ D'I) Dll77 7l7l□ 1-833-584-1829 (TTY: 711)]917 .'?□,m□]19 "79 7Jl77'l711□ 7'1□]l7ll7T]DNl)7□9 I)J'7D'7DI"]'N l7'"□1)7N9l'□]7l7Dillm" Ol70'117l70 11□ '17';] '7'7'lj)1N I)J-'0□9 -I"N 7N9 7Jl77'l711□]l7ll7T Ol70'117l70 '17';] 7N79ill l7DO'Tm□ ,ill'I'□ Dll77 7'□ J'I□ D (Yiddish) .7l71"11□79 7l7"N

Deitsch

WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa diffemti Sadde Hilf griege, wasewwer as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Ei\.i\.r,vtKa

nPOIOXH: Eav µLAaTE Eil.il.r,vtKa, urrapxouv lita8!'mµE, liwpEav urrr,prniE, urroaT□PL□fl, aTr, auyKEKptµ!':vr, y:>..waaa. lhmi8EvTm liwpEav Kmai\.i\.r,:l..a por,8□µarn Km urrr,prniE, ym rrapox□ rr:>..r,po¢optwv a£ rrpoapamµE, µop¢!':,. KaMaTE rn 1-844-465-1714 (TTY: 711) □ arrEU8uv8EiTE arnv rrapox6 aa,. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Orama)

Gagana Samoa

FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. 0 le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Viii le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)