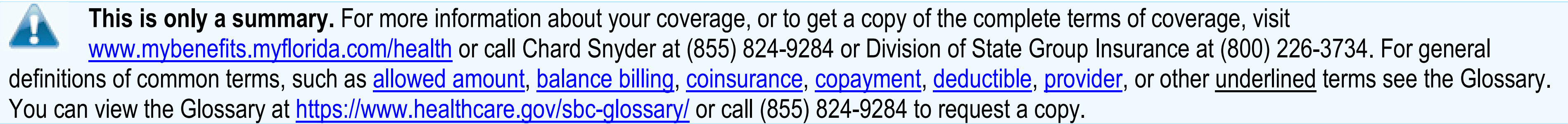

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.mybenefits.myflorida.com/health or call Chard Snyder at (855) 824-9284 or Division of State Group Insurance at (800) 226-3734. For general definitions of common terms, such 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 call (855) 824-9284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 All Coverages	This Health Reimbursement Account (HRA) plan may help you pay for some of the deductible expenses associated with your major medical plan. Check your major medical plan's Summary of Benefits and Coverage (SBC) for overall deductible.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't met the deductible amount of your major medical plan. This plan generally provides coverage for substantiated out-of-pocket medical expenses for services up to the available HRA balance.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services for this plan. Check your major medical plan's SBC for other deductibles for specific services. This HRA may be used to offset all or a portion of your deductible under a major medical plan. The HRA can only reimburse substantiated medical expenses for services up to the available HRA balance.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses. The HRA can only reimburse substantiated medical expenses for services up to the available HRA balance.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
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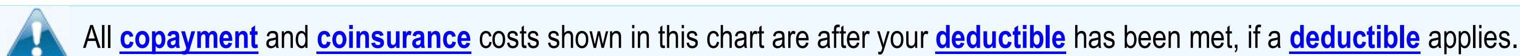
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/sofrxplan	Generic drugs	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
	Inpatient services			
If you are pregnant	Office visits	N/A		

* For more information about limitations and exceptions, see the plan or policy document by calling (855) 824-9284 .

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)	
	Childbirth/delivery professional services Childbirth/delivery facility services			Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*
If your child needs dental or eye care	Children's eye exam Children's glasses Children's dental check-up	N/A		Only expenses for unreimbursed qualified medical care up to the HRA available account balance are covered.*

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
- Long term care
- Any expense payable through another source (such as a health insurance plan)
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture
- Bariatric surgery if it is to treat a medical condition
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Private-duty nursing if it is to treat a medical condition
- Routine foot care if it is to treat a medical condition
- Routine eye care (Adult)
- Weight loss programs if it is to treat a medical condition

* For more information about limitations and exceptions, see the plan or policy document by calling (855) 824-9284 .

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 Employee Benefits Security Administration, (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 (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: Chard Snyder at (855) 824-9284.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? No

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. However, please also refer to the SBC for your medical health plan.

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 (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** **$5,000**
- **Specialist deductible** **N/A**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,000***

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

- **The plan's overall deductible** **$7,500**
- **Specialist deductible** **N/A**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$7,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$7,400***

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

- **The plan's overall deductible** **$10,000**
- **Specialist deductible** **N/A**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$10,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900***

*The amount paid by the HRA **plan** will depend on the items submitted for reimbursement by the covered individual. No amounts are paid automatically. The amount paid by the HRA **plan** is limited to the available account balance. The covered individual may be responsible for amounts in excess of the available account balance. Refer to the SBC for your health plan for additional information