Summary of PPO Benefits

Benefit Period April 1, 2025 -March 31, 2026

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

ICUBA High Deductible PPO Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Healthcare Coverage Summary		
Deductible Per Benefit Period (PBP)		
Individual Family	$4,500 $9,000	$8,500 $17,000
Coinsurance	30%	50%
Out-of-Pocket Maximums PBP *(includes medical deductible, medical coinsurance, and medical copays)*		
Individual Family	$7,200 $14,400	$12,700 $25,400
Lifetime Maximum	No Maximum	
Physician Office Visits *(Internal Medicine, General Practice, Family Practice, Pediatrician, OB/GYN)*	$15 copay (not subject to deductible)	50% after deductible
Total Care Physician Office Visit *(Internist, Family Practice, Pediatrician)*	0% (not subject to deductible)	Not Applicable
Embold Physician Office Visit	0% (not subject to deductible)	Not Applicable
Teladoc Telemedicine Visit	0% after $5 copay	Not Applicable
Maternity Office Visit Benefit *(initial OB visit only)*	$15 copay (not subject to deductible)	50% after deductible
Specialist Office Visits	$35 copay (not subject to deductible)	50% after deductible
Independent Clinical Labs (medically necessary)[1]		
Quest Diagnostics and office visits Outpatient Facility (Hospital setting) [2]	0% (not subject to deductible) 30% coinsurance	50% after deductible
Preventive Care *Annual Physical and Gynecological exam*	0% (not subject to deductible)	Not Covered
Chlamydia and STD tests	0% (not subject to deductible)	Not Covered
PAP tests	0% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	0% (not subject to deductible)	Not Covered
Mammograms and Ultrasounds of the Breast	0% (not subject to deductible)	Not Covered
Urinalysis	0% (not subject to deductible)	Not Covered
Venipuncture/Conveyance Fee	0% (not subject to deductible)	Not Covered
General Health Blood Panel *Glucose Test, Lipid Panel, Cholesterol, and ALT/AST*	0% (not subject to deductible)	Not Covered
Adult and Pediatric Immunizations	0% (not subject to deductible)	Not Covered
Related Wellness Services *(e.g., blood stool tests, colonoscopies, sigmoidoscopies, electrocardiograms, echocardiograms, and bone mineral density tests)*	0% (not subject to deductible)	Not Covered
Allergy Injections	0% (not subject to deductible)	50% after deductible
Emergency Room Services	0% after $500 copay (waived if admitted)	
Medically Necessary Emergency Transportation	0% after $250 copay	
Convenient Care Clinic (Retail) *Minute Clinic- CVS/Healthcare Clinic - Walgreens*	0% after $10 copay	
Urgent Care Center	0% after $30 copay	
Hospital Expenses Inpatient	30% after deductible	50% after deductible
Outpatient	30% after deductible	50% after deductible
Outpatient Surgery Office Setting *(Physician or Specialist)*	30% (not subject to deductible)	50% after deductible

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Outpatient Facility	30% after deductible	50% after deductible
Related professional services	30% after deductible	50% after deductible
Non-Emergent Surgeries with Lantern Please call 855-200-2119 for this separate benefit	Deductible/Coinsurance waived when utilizing Lantern services and network	Not Covered
Infertility Services *(Counseling and testing to diagnose only)*	30% after deductible	50% after deductible
Outpatient Physical Therapy	$20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Speech Therapy *(Restorative services only)*	$20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Outpatient Occupational Therapy	$20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Spinal Manipulation	$20 copay (not subject to deductible)	50% after deductible
	Limit: 60 visits/ benefit period	
Diagnostic Services (X-Ray and other tests)	30% after deductible	50% after deductible
Outpatient Diagnostic Imaging *(MRI, MRA, CAT Scan, PET Scan)*	Allowed Charges up to $500 Copay	50% after deductible
Durable Medical Equipment	30% after deductible	50% after deductible
Prosthetic Appliances	30% after deductible	50% after deductible
Hearing Care Services		
Hearing aid screening/exam	30% (not subject to deductible)	
Hearing aid	30% after in-network deductible	
	Combined limit: $1,500/ benefit period	
Temporomandibular Joint Disorder (Medical necessity required; excludes appliances and orthodontic treatment)	30% after deductible	50% after deductible
Inpatient Rehabilitation	30% after deductible	50% after deductible
	Limit: 60 days/ benefit period	
Skilled Nursing Rehabilitation	30% after deductible	50% after deductible
	Limit: 60 days/ benefit period	
Home Health Care	30% after deductible	50% after deductible
Private Duty Nursing	30% after deductible	50% after deductible
Hospice: Inpatient and Outpatient	0% (not subject to deductible)	50% after deductible
Mental Health and Substance Abuse Coverage Summary		
Mental Health or Substance Abuse Inpatient	30% after deductible	50% after deductible
Outpatient	$15 copay (not subject to deductible)	50% after deductible
Inpatient [3]	30% after deductible	50% after deductible
Mental Health Hospital Admission [3]	30% after deductible	50% after deductible
Substance Abuse Hospital Admission [3]	30% after deductible	50% after deductible
Residential [3] Residential Services focus on evaluating and stabilizing the patient. They help the patient learn effective ways to cope with the symptoms and impact of the patient's illness.	30% after deductible	50% after deductible
Inpatient Detoxification [3] Inpatient detoxification provides 24 hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. Patients typically stay in detoxification only as long as their withdrawalsymptoms require 24 hour medical and nursing services.	30% after deductible	50% after deductible
Outpatient	$15 copay (not subject to deductible)	50% after deductible
Professional Counselling Sessions Talk with a licensed clinician regarding anxiety, attention deficit hyperactivity disorder (ADHD), depression, mood disorders, oppositional defiance disorder (ODD), schizophrenia, trauma, etc.	$15 copay (not subject to deductible)	50% after deductible

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed are Employee responsibility)	
Psychiatric Medication Evaluation	$15 copay (not subject to deductible)	50% after deductible
Applied Behavioral Analysis Therapy [3] Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis.	$15 copay (not subject to deductible)	50% after deductible
Partial Hospitalization (PHP) [3] These programs are longer and more intensive than an IOP, usually 4-6 hours per day, 5-7 days per week. Services include physician and nursing services, as well as group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services. These programs are often used in lieu of an inpatient stay, or as a transition from an inpatient stay.	$15 copay (not subject to deductible)	50% after deductible
Outpatient Detoxification Monitor withdrawal from alcohol or another substance of abuse and may administer medications that assist with detoxification and recovery from addiction.	$15 copay (not subject to deductible)	50% after deductible
Intensive Outpatient Sessions (IOP) These planned and structured programs are usually 2-3 hours/day (or evening), and 3-7 days per week. They may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and other services.	$15 copay (not subject to deductible)	50% after deductible
Pharmacy Benefit Coverage Summary [4]		
Prescription Pharmacy Drug Tier	**Retail: Up to 30 day supply**	**Retail or Mail: Up to 90 day supply**
Low Cost Generics at the NSU Pharmacy	$0 copayment	$0 copayment
Low Cost Generics at all other network pharmacies	$5 copayment	$10 copayment
Preventive Generics [5]	$0 copayment	
Generics: [6] *Tier 1 Medications on the Premium Formulary*	$10 copayment	$20 copayment
Preferred Brand: [6] *Tier 2 Medications on the Premium Formulary*	$55 copayment	$110 copayment
Non-Preferred Brand: [6] *Tier 3 Medications on the Premium Formulary*	$95 copayment	$190 copayment
Preferred Specialty Medication [7] *Required to use Optum Specialty Pharmacy*	20% coinsurance not to exceed $500 per covered prescription	
Non-Preferred Specialty Medication [7] *Required to use Optum Specialty Pharmacy*	20% coinsurance not to exceed $500 per covered prescription	

This summary does not constitute a contract for benefits, the information displayed here is only a summary of the benefits and programs available. Please review the Plan Document provided by your employer for a comprehensive list of covered services. Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.

1. Quest Diagnostic Labs is the In-Network Lab for BlueCross BlueShield of Florida.

2. Outpatient Facility Lab – If you go to your doctor's office at/in a hospital facility and have lab work done (ex: Moffitt Center)

3. Services require prior-authorization

4. Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.

5. Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

6. The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

7. Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products.

Customer Care		
Florida Blue Care Connected	(855) 258-9029	https://member.myhealthtoolkitfl.com/
Florida Blue Nurse Case Manager	(855) 263-0675 ext. 40471	https://member.myhealthtoolkitfl.com/
Florida Blue Behavioral Health Case Manager	(800) 868-1032	https://member.myhealthtoolkitfl.com/
Quest Diagnostics	(866) 697-8378	https://Questdiagnostics.com
Optum Specialty Pharmacy	(855) 258-9029	https://member.myhealthtoolkitfl.com/
ICUBAcares Pharmacist Advocate	(877) 286-3967	https://www.icubacares.org/
Lantern	(855) 200-2099	https://my.lanterncare.com/
Virta	https://www.virtahealth.com/contact	https://www.virtahealth.com/join/icuba
Hinge Health	(855) 902-2777	https://www.hingehealth.com/for/icuba/

ATTENTION ICUBA MEMBERS

ICUBA April 1, 2025 – March 31, 2026 Prescription Medication Plan

ICUBA Pharmacy Benefit Prescription Plan Summary

30-Day Supply
Nationwide Pharmacy Network
You have access to more than 62,000 chain and independent pharmacies including: Costco, CVS, Publix Super Markets Inc., Walgreens, Target, The Medicine Shoppe, Walmart, Winn-Dixie Stores, Inc.

90-Day Supply
Convenient Mail Service Pharmacy
Home Delivery is an easy way to receive up to a 90-day supply of your maintenance medication delivered by mail to your door. Standard shipping is free. Orders are shipped in confidential, tamper-evident packaging from Home Delivery pharmacies.

90-Day at Retail Program
This program allows you to obtain a 90-day supply of your maintenance medication at more than 45,000 participating community pharmacies.

Out-of-Pocket Maximum
In-network Rx copays will be applied toward an individual maximum out-of-pocket of $2,000 and $4,000 for family. Once you reach your out-of-pocket maximum, your prescriptions will be paid at 100% by the plan and no cost to you ($0 copay).

Diabetic Supplies
The following prescribed diabetic supplies are covered at 100%, $0 copay: meters, lancets, lancing devices, test strips, control solution, insulin needles and syringes.

Rx with Over-the-Counter (OTC) alternatives
The Rx with OTC strategy excludes certain prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

Over-The-Counter and Generic Preventive Medications
With a prescription from your physician, the following OTC and generic preventive medications are covered as part of your pharmacy benefit with $0 copay: Aspirin for adults, prenatal vitamins or folic acid for women planning or capable of pregnancy, iron supplementation, oral fluoride supplementation for children, vaccines, Vitamin D for adults, bowel preparation agents for colorectal cancer screening, and select statins for prevention of cardiovascular disease (CVD).

Tobacco Cessation
Tobacco cessation medications are covered with $0 copay when you participate in coaching or counseling options though local Area Health Education Centers, BCBS telephonic coaching or Resources for Living counseling.

Specialty Medications
Certain medications used for treating complex health conditions (e.g. Hepatitis, HIV/AIDS, Oncology, etc.) must be obtained through Optum Specialty Pharmacy with BlueCross BlueShield.

MyRx Toolkit and MyHealthToolkit
Find answers by visiting the **MyRx Toolkit** and **MyHealth Toolkit** through the single sign-on section at http://ICUBAbenefits.org to find your lowest copay, manage Home Delivery prescriptions, keep track of your health history and more!

Care Connected in your Corner
If you have a question about your pharmacy benefit, call the Care Connected team toll-free at **(855) 258-9029**, 24 hours a day, 7 days a week.

ICUBAcares
Real Pharmacists. Real Advocates. Real Solutions.

If you have a question about your pharmacy benefit, and would like to speak with a Pharmacist at ICUBAcares, call **(877) 286-3967.**

Copayments	Prescription-Fill Methods*		
Tier	**Retail: Up to a 30-day supply**	***90-Day at Retail Program* Up to a 90-day supply**	**Mail: Up to a 90-day supply**
Low Cost Generics at the Nova Southeast University (NSU) Pharmacy	$0	$0	N/A
Low Cost Generics at all other network pharmacies	$5	$10	$10
Preventive Generics****	$0	$0	$0
Generics: Tier 1 Medications on the Premium Formulary (PF)**	$10	$20	$20
Preferred Brands: Tier 2) Medications on the Premium Formulary	$55	$110	$110
Non-Preferred Brands: Tier 3 Medications Premium Formulary	$95	$180	$180
Preferred specialty at Optum Specialty Pharmacy***	20% coinsurance	N/A	N/A
Non-preferred specialty at Optum Specialty Pharmacy***	20% coinsurance	N/A	N/A

‡ Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your physician may be asked to provide additional information to determine medical necessity.

* Unless medically necessary, members will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic equivalent is available.

** The PF is a list of medications preferred by your plan that can help you maximize your pharmacy benefit by minimizing your prescription costs.

*** Specialty medications are limited to a 30 Day Supply. Copay Assistance Cards are acceptable to preferred specialty products. Coinsurance not to exceed $500 per prescription, covered at 100% once pharmacy out-of-pocket maximum has been satisfied

**** Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay)

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 visit http://icubabenefits.org or by calling 1-866-377-5102. 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 **1-855-258-9029** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$4,500** in-network per person; **$9,000** family/**$8,500** out-of-network per person; **$17,000** family.	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. The deductible starts over each April 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Deductible doesn't apply to in-network: preventive care, Teladoc, office visits, prescription drugs, outpatient facility labs, or advanced imaging. Doesn't apply to in- or out-of-network: emergency room, urgent care, convenient care, or emergency transportation.	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 do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$7,200** in-network per person; **$14,400** family/ **$12,700** out-of-network per person/ **$25,400** family. There is a separate out-of-pocket limit for prescription drugs (see page 3).	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 http://myhealthtoolkitfl.com, contact Essential Advocate at 1-888-521-2583 or call BCBS customer service at 1-855-258-9029 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. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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 (No Deductible)	Primary care visit to treat an injury or illness	$15 Copayment/Visit	Deductible + 50% Coinsurance	Additional cost shares may apply for physician administered drugs. Embold Health Primary Care, Pediatrics, Cardiology, Dermatology, Endocrinology, Ortho Joint-Spine, Gastroenterology, Neurology, Obstetrics and Gynecology, Podiatry, Pulmonology, Urology, Ophthalmology, General, Bariatric and Lung Cancer Surgery. (Orthopedic/Neurosurgical). Visits Are Always Free. Therapy and Chiropractic visits are limited to 60 each per Plan Year.
	Blue Distinction Total Care (Family Practice, Internal Medicine, Pediatrics)	$0 Copayment/Visit	Not Applicable	
	Embold Health	$0 Copayment/Visit	Not Covered	
	Specialist visit	$35 Copayment/Visit	Deductible + 50% Coinsurance	
	Convenient Care Clinic	$10 Copayment/Visit	$10 Copayment/visit	
	Physical/Occupational/Speech Therapy and Chiropractor Visits	$20 Copayment/Visit	Deductible + 50% Coinsurance	
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

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)	
	Diagnostic test (blood work)	$0 for Quest Diagnostic Laboratories; 30% Coinsurance for clinical outpatient facility labs	Deductible + 50% Coinsurance	Must be medically necessary.
If you have a test	X-Ray	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$500 Copay (or actual cost if less) for family physician, Independent Diagnostic Testing Center, and Outpatient Hospital facility	Deductible + 50% Coinsurance family physician, Independent Diagnostic Testing Center and Outpatient Hospital facility	Prior Authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MyHealthToolkitFL.com **(No Deductible)** Out of pocket limit is $2,000 in-network for individual, $4,000 family. No limit for out-of-network.	Preferred Generic drugs	$0 Copay/Prescription (retail 30 and 90-day at NSU pharmacy, NCPDP# 1082041) $5 Copay/Prescription (retail 30-day) $10 Copay/Prescription (retail 90-day) $10 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	**Retail 30:** 30 day supply; **Retail 90:** 84-91 day supply; **Mail Order:** 84–91 day supply **Specialty Drugs:** Certain medications used for treating complex health conditions must be obtained through the specialty pharmacy program. Manufacturer coupons may not be applied to copay for non-preferred specialty drugs. Prescribed preventive generic medications to treat one of the conditions designated Essential Health
	Non-Preferred Generic drugs	$10 Copay/Prescription (retail 30-day) $20 Copay/Prescription (retail 90-day) $20 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Preferred brand drugs	$55 Copay/Prescription (retail 30-day) $110 Copay/Prescription (retail 90-day) $110 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Non-Preferred brand drugs	$95 Copay/Prescription (retail 30-day) $190 Copay/Prescription (retail 90-day) $190 Copay/Prescription (mail order)	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
	Preferred Specialty drugs	20% Coinsurance not to exceed $500 per prescription	40% Coinsurance (after payment in full and filing	

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)	
			paper claim for reimbursement)	Benefit by the Affordable Care Act, such as hyperlipidemia, have a $0 copay. Certain additional requirements such as age, sex, and diagnosis may also need to be met.
	Non-Preferred Specialty drugs	20% Coinsurance not to exceed $500 per prescription	40% Coinsurance (after payment in full and filing paper claim for reimbursement)	
If you have outpatient surgery (Must meet Deductible)	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance for Outpatient Hospital Facility $35 Copayment for Outpatient Surgery Office Setting for Specialist.	Deductible + 50% Coinsurance for Outpatient Hospital Facility	None
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	None
If you need immediate medical attention (No Deductible)	Emergency room care	$500 Copayment	$500 Copayment	Waived if Admitted
	Emergency medical transportation	$250 Copayment	$250 Copayment	None
	Urgent care	$30 Copayment/Visit	$30 Copayment/Visit	None
	Teladoc Medicine	$5 Copayment/Visit	Not Covered	None
If you have a hospital stay (Must meet Deductible)	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services are limited to 60 days per benefit period.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services Inpatient: **(Must Meet Deductible)** Outpatient: **(No**	Outpatient services	$15 Copayment/Visit	Deductible + 50% Coinsurance	None
	Inpatient services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Prior Authorization required. Inpatient Rehabilitation Services limited to 60 days per Plan Year

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)	
Deductible) For more information on Behavioral Health and Substance Abuse call: 1-800-868-1032				
If you are pregnant **(In-network: Full deductible not required until delivery)**	Prenatal and postnatal care	$15 Copayment (Initial Visit Only)	Deductible + 50% Coinsurance	None
	Childbirth/delivery and all facility services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Prior Authorization required
	Rehabilitation services	$20 Copayment/Visit for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Deductible + 50% Coinsurance for Specialist Office, Outpatient Rehabilitation Facility and Outpatient Hospital Facility	Up to 60 combined visits per benefit period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not Covered, except for Autism Benefits	Not Covered, except for Autism Benefits	Prior Authorization required
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Up to 60 visits per benefit period
	Durable medical equipment	Deductible + 30% Coinsurance Deductible is limited to $2,000 and counts towards the plan's overall deductible	Deductible + 50% Coinsurance	Prior Authorization required
	Hospice services	No Charge	Deductible + 50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's glasses	Covered under Vision Plan	See Vision Plan	See Vision Plan
	Children's dental check-up	Covered under Dental Plan	See Dental Plan	See Dental Plan

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
- Long-Term Care
- Weight loss programs
- Cosmetic surgery
- Routine Eye Care
- Infertility treatments
- Dental care
- Routine Foot Care unless for diabetic treatment
- Weight Management (except through My Health Novel)

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

- Diagnosis of Infertility
- Bariatric Surgery with prior authorization
- Chiropractic Care
- Coverage provided outside the United States. See www.bluecardworldwide.com
- Hearing Aids
- Non-emergency care when traveling outside the United States

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-258-9029. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact any or all of the following:

• 1-855-258-9029 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.

Language Access Services:

To obtain assistance in your specific language, call the customer service number shown on the first page of this notice.
Spanish: Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.
Tagalog: Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng customer service na makikita sa unang pahina ng paunawang ito.
Chinese: 如需中文服务，请致电列于本通知首页的客户服务号码。

Navajo: T'áá Dinéjí shił hane'go shiká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyí'niligíí akáa'gi siltsoozígíí bikáá' ííshjáąh.

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	$4,500
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$12,991**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$35
Coinsurance	$1,315
The total Peg would pay is	**$5,850**

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

The plan's overall deductible	$4,500
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$7,690**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$815
Coinsurance	$0
The total Joe would pay is	**$815**

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

The plan's overall deductible	$4,500
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,187**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$183
Copayments	$780
Coinsurance	$0
The total Mia would pay is	**$963**

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

LANTERN

INDEPENDENT COLLEGES AND UNIVERSITIES ICUBA BENEFITS ASSOCIATION

Formerly Known As Surgery Plus Same Trusted Team

Lighting Your Path to the Right Surgical Care

What is Lantern?

Lantern can help you get the best care when you need planned, nonemergency surgery. This money-saving benefit is available at no additional cost to you as part of your benefits.

Here's What's Covered

In partnership with ICUBA, we cover the most expensive costs associated with surgery, so you'll pay less for your procedure when you use your Lantern benefit. Your coverage includes:*

- Dedicated support and guidance
- Personalized matching with the best surgeon for your unique needs
- Consults and appointments with your Lantern surgeon
- Anesthesia, procedure and facility (hospital) fees

Let Us Guide You Back to Health

3 Steps to the Best Care

STEP 1

Call a Care Advocate to get started. They'll share more information about your benefits and ask about the care you're looking for.

STEP 2

Based on your needs, your Care Advocate will match you with a hand-picked list of excellent surgeons.

STEP 3

After you choose a surgeon, your Care Advocate will help set up appointments and guide you through every step of the experience.

Call Us to Learn More at 855 200 2119

* Testing, scans, imaging, durable medical equipment, and physical therapy expenses may not be included. However, coverage may be available through your medical plan.

In the event of a medical emergency, call 911 or visit your nearest emergency room.

LANTERN

INDEPENDENT COLLEGES AND UNIVERSITIES ICUBA BENEFITS ASSOCIATION

Anteriormente Conocido Como Surgery Plus · Mismo Equipo de Confianza

Iluminando Su Camino a la Atención Quirúrgica Adecuada

¿Qué es Lantern?

Lantern puede ayudarlo a obtener la mejor atención cuando necesite una cirugía planificada que no sea de emergencia. Este beneficio de ahorro de dinero está disponible sin costo adicional para usted como parte de sus beneficios.

Lo Que Está Cubierto

En colaboración con ICUBA cubrimos los costos más elevados de la cirugía, por lo que pagará menos por el procedimiento cuando utilice el beneficio de Lantern. La cobertura incluye lo siguiente:*

- Apoyo y guía dedicados
- Asignación personalizada al cirujano que mejor se adapte a sus necesidades
- Consultas y citas con su cirujano de Lantern
- Tarifas de anestesia, procedimientos y establecimiento (hospital)

Permítanos Devolverle Su Salud

3 Pasos para Recibir la Mejor Atención

PASO 1

Llame a un defensor de atención para comenzar. Le compartirá más información sobre sus beneficios y le preguntará sobre la atención que está buscando.

PASO 2

En función de sus necesidades, su defensor de atención le asignará una lista cuidadosamente seleccionada de excelentes cirujanos.

PASO 3

Después de elegir un cirujano, su defensor de atención lo ayudará a programar citas y lo guiará en cada paso de la experiencia.

Llámanos al 855 200 2119

* Es posible que no se incluyan los gastos de pruebas, exámenes, diagnósticos por imágenes, equipos médicos durables y fisioterapia. Sin embargo, pueden estar cubiertos por su plan médico.

En caso de una emergencia médica, llame al 911 o visite la sala de emergencias más cercana.

Your partner for pain relief

With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best.

Specialized care, personalized for you

Reduce everyday joint and muscle aches. Recover from an injury. Relieve pelvic pain and discomfort.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Access to Hinge Health Enso® a non-addictive, FDA-cleared wearable device to calm and soothe pain flare-ups in minutes

$0
cost to you

Scan the QR code or visit:
hinge.health/icuba-join

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

A HINGE HEALTH EXCLUSIVE

Meet Enso

The small device for pain relief on-the-go.

*Eligibility to receive Hinge Health Enso is based on the program in which you are placed, fulfillment of clinical eligibility criteria, and completion of a qualifying number of exercise sessions.

Members and dependents 18+ enrolled in a Blue Cross Blue Shield ICUBA medical plan are eligible.

Your covered diabetes reversal* benefit

No fad diets or extra gym visits—just foods that are right for you

Virta is your guided nutrition program—available at **$0 cost to you**. Personalized to your lifestyle and health goals, Virta uses nutrition science to build custom plans that help you lose weight, lower your blood sugar, and transform your health.

Join the thousands of people using Virta and transforming their lives

"The most surprising thing about Virta is how much I enjoy my new way of eating. I've lost 30 pounds and have been able to maintain it, and my life no longer revolves around my diabetes meds."

Ricardo, Virta member

Virta is your fully-covered benefit for better health.

Get personalized nutrition support at no cost to you.

Claim my benefit

At $0 cost to you, you'll receive:

- Personalized health coaching
- Connected weight scale and blood meter
- Exclusive nutrition resources and recipes
- Dedicated medical guidance

Visit **www.virtahealth.com/join/icuba** or scan the QR code to claim your benefit today.

virta

Virta is available to ICUBA members and eligible dependents between the ages of 18 and 79. This benefit is currently being offered to those with type 2 diabetes. There are some medical conditions that would exclude patients from the Virta treatment. Start the application process now to find out if you qualify.

* Reversal on Virta is defined by reaching an A1c below 6.5% without the use of diabetes medications beyond metformin. Diabetes and related issues can return if lifestyle changes are not maintained.

Your covered weight loss benefit

No fad diets or extra gym visits—just foods that are right for you Virta is your guided nutrition program—available at **$0 cost to you.** Personalized to your lifestyle and health goals, Virta uses nutrition science to build custom plans that help you sustainably lose weight and transform your health.

Virta is your fully-covered benefit for better health.

Get personalized nutrition support at no cost to you.

Join the thousands of people using Virta and transforming their lives

"I FEEL wonderful. For the first time in my life, I am losing weight safely and eating real food. The plan is easy to follow, and the weight loss has been so surprising that I've had to buy new clothes already."

Bob, Virta member

At $0 cost to you, you'll receive:

- Personalized health coaching
- Connected weight scale
- Exclusive nutrition resources and recipes
- Dedicated medical guidance

Visit **virtahealth.com/join/optumrx** or scan the QR code to claim your benefit today.

Virta Health's nutrition therapy care plans may be suitable for adults (18+) with certain metabolic health conditions. For more information and to confirm eligibility, please visit: www.virtahealth.com/join/optumrx and click 'Join Now' to start your application. Members were selected to receive this communication based on pharmacy claims data. Information in this letter is confidential and not shared with any non-medical personnel or personnel not directly managing pharmacy claims. Medications listed in this letter are subject to change. This document and others, if attached, contain information from Optum Rx that is proprietary, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to Optum Rx, PO Box 2749, Shawnee Mission, KS 66201

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