Florida School Book Depository Health Benefit Plan **Effective March 1, 2021**
Medical Summary of Benefits

Refer to the Plan Document and Summary Plan Description for details of Coverage.

Medical Benefits	CIGNA PPO Network Providers www.Cigna.com	Non-PPO Providers
Calendar Year Deductible	$750 per individual $1,500 per family (accumulative)	$1,500 per individual $3,000 per family (accumulative)
	Calendar Year deductible does not include Prescription Drug Co-payments or pre-certification penalties. PPO and Non-PPO deductibles shall combine together.	
Coinsurance	80% of covered expenses after Calendar Year deductible is satisfied.	60% of covered expenses after Calendar Year deductible is satisfied.
Out-of-Pocket Maximum	$4,000 per individual $8,000 per family (accumulative)	Unlimited.
	Out-of-pocket expenses include the Calendar Year deductible, Coinsurance and Prescription Drug Co-payments. Non-covered expenses & pre-certification penalties DO NOT apply toward the Out-of-Pocket Maximum. PPO and Non-PPO Out-of-Pocket Maximums shall combine together.	
Lifetime Maximum Benefit	Unlimited.	
Alcohol & Substance Abuse Treatment	**Inpatient Hospitalization:** 80% Coinsurance following $100 inpatient admission deductible; subject to Calendar Year deductible. **Outpatient Services:** 80% Coinsurance; subject to the Calendar Year deductible.	**Inpatient Hospitalization:** 60% Coinsurance following $100 inpatient admission deductible; subject to Calendar Year deductible. **Outpatient Services:** 60% Coinsurance; subject to Calendar Year deductible.
Allergy Services	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Ambulance Services	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Birthing Center	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Durable Medical Equipment	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Emergency Room Services	80% Coinsurance following $25 per visit Emergency Room deductible; subject to the Calendar Year deductible. Emergency Room deductible will be waived if the patient is admitted into the hospital from the emergency room.	
Extended Care Facility	80% of facility's semiprivate room rate; subject to the Calendar Year deductible.	60% of facility's semiprivate room rate; subject to Calendar Year deductible.
	Includes Rehabilitation Facility & Skilled Nursing Facility.	
Home Health Care	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Hospice Care Includes Bereavement Counseling	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Inpatient Hospital Services Includes Physician Services	80% of facility semiprivate room rate following $100 inpatient admission deductible; subject to Calendar Year deductible.	60% of facility semiprivate room rate following $100 inpatient admission deductible; subject to Calendar Year deductible.
Maternity Care	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
	Refer to Inpatient Hospital Services for benefits payable in connection with delivery in a Hospital.	
Mental Health Services	**Inpatient Hospitalization:** 80% Coinsurance following a $100 inpatient admission deductible; subject to Calendar Year deductible. **Outpatient Services:** 80% Coinsurance; subject to the Calendar Year deductible.	**Inpatient Hospitalization:** 60% Coinsurance following a $100 inpatient admission deductible; subject to Calendar Year deductible. **Outpatient Services:** 60% Coinsurance; subject to Calendar Year deductible.
Occupational Therapy	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Outpatient X-Ray, Laboratory & Diagnostic Services	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Outpatient Physical Therapy	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Outpatient Physician Office Visit Services	**UCM Digital Health telemedicine visit: $0 Co-payment.** All other Physician office visits: 80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Outpatient Private Duty Nursing	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.

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Outpatient Surgery	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Pre-Admission Testing	100% of covered expenses; not subject to Calendar Year deductible. Testing must occur on outpatient basis within 7 days of inpatient hospital admission.	60% Coinsurance; subject to Calendar Year deductible.
Pre-Certification Requirements Emergency admissions must be approved within 48 hours.	**Pre-admission certification is required for the following services:** Hospitalizations; Home Health Care; Durable Medical Equipment (over $500) MRI/CAT Scans; Hospice Care; Outpatient Surgical Procedures (does not include surgery in Physician's office) Extended Care Facility; Psychological Testing Dialysis; Cardiac Rehabilitation Failure to comply will reduce all eligible charges by the lesser of $2,500.00 or 50%.	
Prescription Drug Benefits Retail Prescriptions (90 day supply maximum) Mail Order Prescriptions (For Maintenance medications only; 90 day supply maximum)	**Retail Network Pharmacy:** (90-day supply maximum) ▪ Generic drugs: $10 Co-payment for each 30-day supply filled. ▪ Brand name drugs: $50 Co-payment for each 30-day supply filled. ▪ Insulin and related diabetic supplies purchased from Pharmacy simultaneously: $12 Co-payment for each 30-day supply filled. **Mail Order Prescriptions:** (90-day supply maximum) ▪ Generic drugs: $20 Co-payment ▪ Brand name drugs: $100 Co-payment ▪ Insulin: $24 Co-payment **Specialty Pharmacy Program** (for certain high-cost drugs) 80% of covered expenses; subject to Calendar Year deductible.	Prescriptions purchased from Non-Participating pharmacies or outside of the prescription drug program are not eligible for reimbursement through the Plan.
Prosthetics / Orthotics	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Routine Well Adult Care (Age 18 and above)	100% of covered expenses; not subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
	This routine benefit includes physician charges for an annual routine examination, routine x-rays and laboratory, immunizations, mammograms and other routine services listed below: ▪ Immunizations. ▪ Fasting lipoprotein profile (cholesterol screening). ▪ Annual Prostate Specific Antigen (PSA) screening. ▪ Fasting blood sugar screening (for diabetes mellitus). ▪ Annual colorectal screening. ▪ Blood pressure screening. ▪ Obesity screening and counseling. ▪ Tobacco use screening and cessation interventions. ▪ ACA required prescription drugs. ▪ Annual vision examination. ▪ Annual hearing examination. ▪ Bone Mineral Density (BMD) screening (once every 24 months). ▪ Women's Health Services to include pelvic exam and Pap test; screening for gestational diabetes; DNA Testing; HPV (Human Papillomavirus); counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; sterilization; and contraceptive methods and counseling. Limitations may apply. **A complete list of covered ACA mandated routine services for women / adults is available at: https://www.healthcare.gov/coverage/preventive-care-benefits/**	
Routine Well Child Care (Birth through age 17)	100% of eligible charges; not subject to the Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
	Includes Office Visit, immunizations, laboratory blood tests and routine vision & hearing screenings.	
Second &Third Surgical Opinion	If required by the Medical Coordinator through the Utilization Review process, Benefits shall be payable at 100% of eligible charges; not subject to the Calendar Year deductible.	
Speech Therapy	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Spinal Manipulation	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Transplant Benefit	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
Urgent Care Facility Services	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.
All Other Covered Medical Expenses	80% Coinsurance; subject to Calendar Year deductible.	60% Coinsurance; subject to Calendar Year deductible.

Questions regarding Coverage and Benefits should be directed to:

Preferred Benefit Administrators, Inc.
407-786-2777 or 888-524-2777
www.PreferredTPA.com

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BENEFIT ADMINISTRATORS
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