Florida Blue

Proposal ID: 5431701

Date: 05/11/2020

Proposal Prepared for Member Insured

Agent Contact Information

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Agent / Agency ID: 015

Agency Contact Information

Name: FWH & ASSOCIATES, INC

Phone: 4078925500

Address: ,

Summary

Individual on Proposals

Relationship	First Name	Gender	Date of Birth	Zip Code	County	Used Tobacco In The Past?
Applicant	Member	Male	01/12/1975	32955	BREVARD	Never

Marketplace

Plan Name	Premium
BlueSelect Silver 1443	$495.61
BlueSelect Bronze 1737S	$409.43

Qualified Dental

Plan Name	Premium
BlueDental Copayment QF	$25.35

Marketplace Details

Proposed Effective Date: **05/11/2020**

Eligible Applicant(s)	Eligibility Status	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Member	Eligible	$495.61	$409.43
Monthly Premium:		$495.61	$409.43
Estimated Subsidy*:		$412.51	$412.51
Adjusted Monthly Premium		$83.10	$0.00

*If no estimated subsidy has been applied, at least one of the members of this proposal has been deemed ineligible.

In-Network Benefits

Metal Level/CSR

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Metal Level	Silver	Bronze
Cost Share Reduction	05	01

Plan Benefits

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Annual Deductible	Medical Deductible: N/A Drug Deductible: N/A Combined Medical and Drug Deductible: Individual: $0 / Family: $0 per person | $0 per group	Medical Deductible: N/A Drug Deductible: N/A Combined Medical and Drug Deductible: Individual: $6,650 / Family: $6650 per person | $13300 per group
Annual Out-of-Pocket Maximum	Medical Benefits: N/A Drug Benefits: N/A Medical and Drug Benefits Total: Individual: $2,700 / Family: $2700 per person | $5400 per group	Medical Benefits: N/A Drug Benefits: N/A Medical and Drug Benefits Total: Individual: $8,150 / Family: $8150 per person | $16300 per group

Prescription Drugs

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Generic Drugs	Copay: $22 In-Network Only: $0 preventive and low cost generics for certain drugs, plus Mail Order for these drugs is $0.	Copay: $35 In-Network Only: $0 preventive and $4 generics for certain drugs, plus Mail Order for these drugs is $0.
Preferred Brand Drugs	Copay: $47 In-Network Only: Certain drugs are available for a lower cost.	In-Network Only: Certain drugs are available for a lower cost. Coinsurance: 40% Coinsurance after deductible
Non-Preferred Brand Drugs	Coinsurance: 40%	Coinsurance: 40% Coinsurance after deductible
Specialty Drugs	Coinsurance: 50%	Coinsurance: 45% Coinsurance after deductible
List of Covered Drugs	Covered	Covered
Three Month Mail Order Pharmacy Benefits	Yes	Yes
Prescription Drug Deductible	Included with Medical Deductible	Included with Medical Deductible

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Prescription Drug Out of Pocket Maximum	N/A	N/A

Physician Office Services

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Primary Care Physician	Copay: $10 In-Network Only: $0 Copayment may apply for the first 3 visits.	Copay: $35
Specialist	Copay: $40	Copay: $75

Emergency and Urgent Care

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Urgent Care Center	Copay: $40	Copay: $75
Emergency Room Facility	Copay: $600	Coinsurance: 40% Coinsurance after deductible

Hospital and Surgical Care

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Outpatient Hospital Facility	Coinsurance: 40%	Coinsurance: 40% Coinsurance after deductible
Inpatient Hospital Facility	Coinsurance: 40%	Coinsurance: 40% Coinsurance after deductible
Physician Services	Copay: No Charge	Coinsurance: 40% Coinsurance after deductible

Outpatient Diagnostic Services

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Laboratory Services	Copay: No Charge	Copay: $25
Basic Imaging (e.g. x-ray, ultrasound)	Copay: $20	Coinsurance: 40% Coinsurance after deductible
Advanced Imaging (e.g. CT/CAT Scan, MRI, MRA)	Coinsurance: 40%	Coinsurance: 40% Coinsurance after deductible

Vision Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Eye Exams for Adults	Not Covered	Not Covered
Routine Eye Exams for Children	Copay: No Charge 1 Visit(s) per Year	Copay: No Charge 1 Visit(s) per Year

Child Dental Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Dental Care	Not Covered	Not Covered
Basic Dental Care	Not Covered	Not Covered
Major Dental Care	Not Covered	Not Covered
Medically Necessary Orthodontia	Not Covered	Not Covered

Adult Dental Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Dental Care	Not Covered	Not Covered
Basic Dental Care	Not Covered	Not Covered
Major Dental Care	Not Covered	Not Covered

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Orthodontia	Not Covered	Not Covered

Other Benefits

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Mental/Behavioral Health Outpatient Services	Copay: $40	Copay: $75
Substance Abuse Dependency Outpatient Services	Copay: $40	Copay: $75
Outpatient Rehabilitation Services	Copay: $40 35 Visit(s) per Benefit Period Combined limit for all outpatient therapy plus chiropractic.	Copay: $75 35 Visit(s) per Benefit Period Combined limit for all outpatient therapy plus chiropractic.
Habilitation Services	Copay: $40 35 Visit(s) per Benefit Period Supplementing with the federal definition of habilitative services: Health care services that help a person keep, learn,	Copay: $75 35 Visit(s) per Benefit Period Supplementing with the federal definition of habilitative services: Health care services that help a person keep, learn,

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
	or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Prenatal and Postnatal - Office Visit	Copay: $40	Copay: $75
Labor and Delivery - Hospital Stay	Coinsurance: 40%	Coinsurance: 40% Coinsurance after deductible

Out-of-Network Benefits

Metal Level/CSR

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Metal Level	Silver	Bronze
Cost Share Reduction	05	01

Plan Benefits

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Annual Deductible	Medical Deductible: N/A Drug Deductible: N/A Combined Medical and Drug Deductible: Individual: $14,000 / Family: $14000 per person | $28000 per group	Medical Deductible: N/A Drug Deductible: N/A Combined Medical and Drug Deductible: Individual: $13,300 / Family: $13300 per person | $26600 per group
Annual Out-of-Pocket Maximum	Medical Benefits: N/A Drug Benefits: N/A Medical and Drug Benefits Total: Individual: $16,300 / Family: $16300 per person | $32600 per group	Medical Benefits: N/A Drug Benefits: N/A Medical and Drug Benefits Total: Individual: $16,300 / Family: $16300 per person | $32600 per group

Prescription Drugs

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Generic Drugs	In-Network Only: $0 preventive and low cost generics for certain drugs, plus Mail Order for these drugs is $0. Coinsurance: 100%	In-Network Only: $0 preventive and $4 generics for certain drugs, plus Mail Order for these drugs is $0. Coinsurance: 100%
Preferred Brand Drugs	In-Network Only: Certain drugs are available for a lower cost. Coinsurance: 100%	In-Network Only: Certain drugs are available for a lower cost. Coinsurance: 100%
Non-Preferred Brand Drugs	Coinsurance: 100%	Coinsurance: 100%
Specialty Drugs	Coinsurance: 100%	Coinsurance: 100%
List of Covered Drugs	Covered	Covered
Three Month Mail Order Pharmacy Benefits	No	No
Prescription Drug Deductible	N/A	N/A
Prescription Drug Out of Pocket Maximum	N/A	N/A

Physician Office Services

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Primary Care Physician	In-Network Only: $0 Copayment may apply for the first 3 visits. Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Specialist	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible

Emergency and Urgent Care

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Urgent Care Center	Copay: $40 Copay after deductible	Copay: $75 Copay after deductible
Emergency Room Facility	Copay: $600	Coinsurance: 40% Coinsurance after deductible

Hospital and Surgical Care

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Outpatient Hospital Facility	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Inpatient Hospital Facility	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Physician Services	Copay: No Charge	Coinsurance: 40% Coinsurance after deductible

Outpatient Diagnostic Services

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
Laboratory Services	Coinsurance: 100%	Coinsurance: 100%
Basic Imaging (e.g. x-ray, ultrasound)	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Advanced Imaging (e.g. CT/CAT Scan, MRI, MRA)	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible

Vision Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Eye Exams for Adults	Not Covered	Not Covered
Routine Eye Exams for Children	1 Visit(s) per Year Coinsurance: 100%	1 Visit(s) per Year Coinsurance: 100%

Child Dental Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Dental Care	Not Covered	Not Covered
Basic Dental Care	Not Covered	Not Covered
Major Dental Care	Not Covered	Not Covered
Medically Necessary Orthodontia	Not Covered	Not Covered

Adult Dental Coverage

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Routine Dental Care	Not Covered	Not Covered
Basic Dental Care	Not Covered	Not Covered
Major Dental Care	Not Covered	Not Covered

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Orthodontia	Not Covered	Not Covered

Other Benefits

Plan Details	BlueSelect Silver 1443	BlueSelect Bronze 1737S
Mental/Behavioral Health Outpatient Services	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Substance Abuse Dependency Outpatient Services	Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible
Outpatient Rehabilitation Services	35 Visit(s) per Benefit Period Combined limit for all outpatient therapy plus chiropractic. Coinsurance: 50% Coinsurance after deductible	35 Visit(s) per Benefit Period Combined limit for all outpatient therapy plus chiropractic. Coinsurance: 50% Coinsurance after deductible
Habilitation Services	35 Visit(s) per Benefit Period Supplementing with the federal definition of	35 Visit(s) per Benefit Period Supplementing with the federal definition of

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
	habilitative services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.	habilitative services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Prenatal and Postnatal - Office Visit	Coinsurance: 50% Coinsurance after deductible Coinsurance: 50% Coinsurance after deductible	Coinsurance: 50% Coinsurance after deductible Coinsurance: 50% Coinsurance after deductible
Labor and Delivery - Hospital Stay	Coinsurance: 50% Coinsurance after	Coinsurance: 50% Coinsurance after

Plan Details	**BlueSelect Silver 1443**	**BlueSelect Bronze 1737S**
	deductible	deductible

Qualified Dental Details

Proposed Effective Date: **05/11/2020**

Eligible Applicant(s)	BlueDental Copayment QF
Member	$25.35
Total Monthly Premium:	$25.35

PEDIATRIC BENEFITS[1]

Plan Details	BlueDental Copayment QF In-Network Benefits	BlueDental Copayment QF Out-Network Benefits
Pediatric Deductible	$25 per person; Combined for In and Out of Network	$25 per person; Combined for In and Out of Network

Plan Details	BlueDental Copayment QF In-Network Benefits	BlueDental Copayment QF Out-Network Benefits
Out of Pocket Maximum if only one child is covered	$350	Unlimited
Out of pocket maximum if more than one child is covered	$700	Unlimited
Preventive Services-Oral Exams, Cleanings, Fluoride, Bitewing X-Rays, Space Maintainers, Sealants	Copayment based on schedule of benefits after deductible	80% covered based on our fee schedule after deductible
Basic Services: Extractions, Oral Surgery, Anesthesia, Emergency (Palliative), Amalgam and Resin Composite Anterior Fillings, Minor services for Periodontics, Endodontics, and Prosthodontics	Copayment based on schedule of benefits after deductible	60% covered based on our fee schedule after deductible

Plan Details	BlueDental Copayment QF In-Network Benefits	BlueDental Copayment QF Out-Network Benefits
Major Services: Inlays and Crowns, Dentures, Bridges, Repair, Restorations - Major, Periodontics - Major, Endodontics - Major, Prosthodontic Services - Major	Copayment based on schedule of benefits after deductible	40% covered based on our fee schedule after deductible
Orthodontia/Implants***: Medically Necessary (prior authorization required)	Copayment based on schedule of benefits after deductible	30% covered based on our fee schedule after deductible

ADULT BENEFITS

Plan Details	BlueDental Copayment QF In-Network Benefits	BlueDental Copayment QF Out-Network Benefits
Deductible (Basic and Major services only)	$50 per person (Basic and Major services only); Combined for In and Out of Network	$50 per person (Basic and Major services only); Combined for In and Out of Network
Preventive Services: Oral Exams, Cleanings, Bitewing X-Rays	Copayment based on schedule of benefits after deductible	80% covered based on our fee schedule after deductible
Basic Services**: Restorations - Minor, X-Rays - complete series, Prosthodontic	Copayment based on schedule of benefits after deductible	60% covered based on our fee schedule after deductible

Plan Details	BlueDental Copayment QF In-Network Benefits	BlueDental Copayment QF Out-Network Benefits
Services - Minor, Emergency		
Major Services**: Inlays and Crowns, Dentures, Bridges, Repair, Restorations - Major, Periodontics - Major, Endodontics - Major, Prosthodontic Services - Major	Copayment based on schedule of benefits after deductible	40% covered based on our fee schedule after deductible
Orthodontia***	Not Covered	Not Covered

Product Rates Are Subject to Change

The premium quoted above includes any rate modification(s) applied to your current policy. This quoted rate is subject to change based on demographics and other factors, such as tobacco status.Health insurance is offered by Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue. HMO coverage is offered by Health Options, Inc., DBA Florida Blue HMO, an HMO affiliate of Blue Cross and Blue Shield of Florida, Inc. Dental, Life and Disability are offered by Florida Combined Life Insurance Company, Inc., DBA Florida Combined Life, Inc. an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.Some policies have limitations and exclusions. For costs and complete details of coverage, call or write the insurance agent. The amount of benefits and premium will vary depending upon the plan selected. If the premium for a health plan is based on specific criteria, it must be stated. Life and Dental plans are offered by Florida Combined Life Insurance Company, Inc., an affiliate of BCBSF. Premium is based on age, gender, county, tobacco usage, etc.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (including	**Dental, life, and disability coverage:**

FEP members):

Section 1557 Coordinator

4800 Deerwood Campus Parkway, DCC 1-7

Jacksonville, FL 32246

1-800-477-3736 x29070

1-800-955-8770 (TTY)

Fax: 1-904-301-1580

section1557coordinator@floridablue.com

Civil Rights Coordinator

17500 Chenal Parkway

Little Rock, AR 72223

1-800-260-0331

1-800-955-8770 (TTY)

civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Health and Vision insurance is offered by Florida Blue.HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental, Life and Disability insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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Florida Blue and Florida Blue HMO (health and vision coverage): 1-877-465-1125

Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892

TTY: 800-955-8770

Have a disability? Speak a language other than English? Call to get help for free.

¿Habla español? ¿Tiene alguna discapacidad? Llame para obtener ayuda de forma gratuita.

Èske w pale kreyòl ayisyen? Èske w andikape? Rele nou pou w jwenn èd gratis.

Quý vị nói tiếng Việt? Quý vị bị khuyết tật? Hãy gọi trợ giúp miễn phí.

Você fala potuguês? Tem alguma deficiência? Telefone para obter assistência.

您会讲中文吗？是否为伤残人士？如需帮助，请拨打我们的免费电话：

Vous parlez français ? Vous avez une incapacité ? Appelez pour recevoir une assistance gratuite.

Nagsasalita ng Tagalog o Filipino? May kapansanan? Tumawag para sa libreng tulong.

Вы говорите по-русски? Вы являетесь инвалидом? Свяжитесь с нами для получения бесплатной помощи по телефону

ل تتحدث (العربية)؟ تعاني من إعاقة؟ اتصل للحصول على مساعدة مجانية.

Parli italiano? Hai una disabilità? Chiama per un'assistenza gratuita.

Sprechen Sie deutsch? Haben Sie eine Behinderung? Rufen Sie an, um kostenlos Hilfe zu erhalten.

한국어 통역이 필요하세요? 장애가 있나요? 전화하시면 무료로 도와드립니다.

Mówisz po polsku? Jesteś osobą niepełnosprawną? Zadzwoń po bezpłatną pomoc.

ગુજરાતી બોલો છો? અક્ષમતા ધરાવો છો? મફત સહાયતા મેળવવા ફોન કરો.

พูดภาษาไทยได้? เป็นผู้พิการใช่หรือไม่? โทรศัพท์ขอรับคำปรึกษาได้ฟรี

日本語をご希望ですか？障害をお持ちですか？無料の電話サービスをご利用ください。

زبان فارسی صحبت می کنید؟ دارای معلولیت هستید؟ برای دریافت کمک رایگان تماس بگیرید

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