OCALA EQUINE HOSPITAL, P.A.
2021 Payroll Deductions

Plan Name:	18901 SimplyBlue Essential	18802 SimplyBlue Predictable Cost	18756 SimplyBlue Predictable Cost	20751 SimplyBlue All Copay	17251 BlueCare All Copay	16003 BlueOptions All Copay
Carrier:	Florida Blue	Florida Blue	Florida Blue	Florida Blue	Florida Blue	Florida Blue
PLAN FEATURES						
Deductible Ind / Fam	$6,700 / $13,400	$1,500 / $3,000	$3,500 / $7,000	$0 / $0	$0 / $0	$3,350 / $6,700
Coinsurance	50%	50%	0%	0%	0%	0%
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	$8,350 / $16,700	$8,000 / $16,000	$7,350 / $14,700	$7,900 / $15,800	$7,000 / $14,000	$8,200 / $16,400
Wellness / Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
PHYSICIAN SERVICES						
PCP Office Copay	$45 Copay	$45 Copay	$35 Copay	$40 Copay	$40 Copay	$25 Copay
Specialist Office Copay	50% after Ded	$85 Copay	$65 Copay	$90 Copay	$80 Copay	$55 Copay
HOSPITAL CARE						
Inpatient Hospital Facility Fee	50% after Ded	50% after Ded	$750 Copay/Day after Ded up to $2,250	$2,000 Copay/Day up to $6,000	$2,500 Copay/Day up to $7,000	Opt 1: $1,000 after Ded; Opt 2: $1,250 after Ded
Outpatient Diagnostic Testing	Lab: $50 Copay, X-ray & Advanced Imaging: 50% after Ded	Lab: $0, X-ray: $150 Copay & Advanced Imaging: $250 Copay	Lab: $60 Copay, X-ray: $200 Copay, & Advanced Imaging: $350 Copay	Lab & X-ray: $0, Advanced Imaging: $600 Copay	Lab: $50 Copay, X-ray: $150 Copay & Advanced Imaging: $750 Copay	Lab: $50 Copay, X-ray: $150 Copay & Advanced Imaging: $350 Copay
Outpatient Surgery Facility Fee	50% after Ded	50% after Ded	$1,000 after Ded	$1,000 Copay	$2,000 Copay	$500/$750 Copay
EMERGENCY MEDICAL CARE						
Emergency Room Facility Fee **Emergency Medical Transportation**	50% after Ded 50% after Ded	$700 Copay 50% after Ded	$550 Copay $0 after Ded	$600 Copay $600 Copay	$700 Copay $0 after Ded	$300 after Ded $0 after Ded
Urgent Care Facility Fee	50% after Ded	$90 Copay	$70 Copay	$95 Copay	$85 Copay	$60 Copay
Referrals	Not Required	Not Required	Not Required	Not Required	Not Required	Not Required
PHARMACY						
Deductible	Medical DED Applies	$5,000 Pharmacy Ded	Medical DED Applies	N/A	N/A	N/A
Prescription Drug Benefit	G: $32	G: $10	G: $30	G: $20	G: $25	G: $15
	PB: 50% after Ded	PB: 50% after Ded	PB: $50	PB: $50	PB: $150	PB: $75
	NPB: 50% after Ded	NPB: 50% after Ded	NPB: 50% after Ded	NPB: $500	NPB: $250	NPB: $150
	S: 50% after Ded	S: 50% after Ded	S: 50% after Ded	S: $500	S: $350	S: $300
OUT-OF- NETWORK						
Deductible Ind / Fam	N/A	N/A	N/A	N/A	N/A	$6,700 / $13,400
Coinsurance	N/A	N/A	N/A	N/A	N/A	50%
Out-of-Pocket Max Ind/Fam (includes Deductible, Copay, Coinsurance + Rx)	N/A	N/A	N/A	N/A	N/A	$16,400 / $32,800

Payroll Deductions

	Current	Renewal	Current	Renewal	Current	Renewal	Current	Renewal	Current	Renewal	Current	Renewal
Employee Only	$ 43.02	$ 56.09	$ 59.88	$ 76.03	$ 73.34	$ 87.99	$ 103.14	$ 118.59	$ 103.56	$ 121.08	$ 159.58	$ 154.15
Employee + Spouse	$ 204.04	$ 230.18	$ 237.77	$ 270.06	$ 264.67	$ 293.97	$ 324.28	$ 355.18	$ 325.12	$ 360.16	$ 437.15	$ 426.30
Employee + Child(ren)	$ 179.88	$ 204.06	$ 211.08	$ 240.96	$ 235.98	$ 263.08	$ 291.11	$ 319.69	$ 291.88	$ 324.30	$ 395.52	$ 385.48
Family	$ 340.90	$ 378.15	$ 388.97	$ 434.99	$ 427.31	$ 469.06	$ 512.24	$ 556.28	$ 513.44	$ 563.37	$ 673.09	$ 657.63

All plans include Pediatric Dental and Vision for dependent children under age 19.

This is only a summary. Please ask your employer if you want more detail about your coverage and costs, or you can get the complete terms in the policy or plan document at the carrier website. In the event there is a conflict between this summary and your carrier coverage documents, the terms and conditions of the coverage documents will control.