

BlueOptions

For Individuals Under 65

Benefit Summary for Health Plan 512



BlueCross BlueShield
of Florida

Understanding Your Share for Covered Services

This health insurance policy¹ has convenient copays for the most commonly used services. The coverage makes it easy to know what you'll have to spend for medical care, no matter what happens.

NetworkBlue² is the Preferred Provider Network designated as "In-Network" for BlueOptions.

Benefits for Covered Services

Amount Member Pays

Benefits for Covered Services	Amount Member Pays
► Office Services	
Physician Office Services In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	\$35 Copayment CYD ³ + 30% Coinsurance ⁴ CYD + 50% Coinsurance \$10 Copayment CYD + 50% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network	\$250 Copayment CYD + 50% Coinsurance
Maternity Initial Visit With many plans a maternity option is available – you can choose to add an endorsement, at an additional rate, that provides benefits for pregnancy and delivery (the endorsement must be in effect for 30 days prior to conception).	Available
Allergy Injections (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	\$10 Copayment CYD + 30% Coinsurance CYD + 50% Coinsurance
Medical Pharmacy (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Provider (\$200 Monthly Out-of-Pocket Maximum ⁵) Out-of-Network	20% Coinsurance CYD + 50% Coinsurance
► Preventive Care	
Adult Wellness Benefit Maximum (PCY ⁶ , includes Well Woman and Routine Adult Physical Exam and Immunizations) In-Network Out-of-Network	No Maximum \$150
Routine Adult Physical Exam and Immunizations (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$35 Copayment 30% Coinsurance 50% Coinsurance
Well Woman Exam (e.g. Annual GYN) (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$35 Copayment 30% Coinsurance 50% Coinsurance
Mammograms (Covered at 100% of Allowed Amount, In- and Out-of-Network)	\$0
Well Child (No PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$35 Copayment 30% Coinsurance 50% Coinsurance

1 Policies have limitations and exclusions and are medically underwritten.

2 Network Blue is one of our Preferred Provider Networks made up of independent hospitals, physicians and ancillary providers.

3 CYD = Calendar Year Deductible

4 Coinsurance is the percentage the member pays for service.

5 In-Network Medical Pharmacy will be paid at 100% for remainder of calendar month once Out-of-Pocket Maximum is met,

6 PCY = Per Calendar Year

Note: Out-of-Network services may be subject to balance billing.

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Benefits for Covered Services

Amount Member Pays

Benefits for Covered Services		Amount Member Pays
<p>► Prescription Drug Program (BlueScript)®</p> <p>For the greatest savings on your prescriptions, always check to see if the pharmacy is in-network for your BlueOptions plan. Your medication will cost you less if you stay in-network. We have identified certain drugs as a 'specialty drug'. These drugs are listed as a 'specialty drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy.</p>		
Pharmacy Deductible (PD)		\$1500 (Brand Only)
In-Network Prescription Drug Program Retail and Specialty Pharmacy – Generic / Brand / Non-Preferred Mail Order (90 days) – Generic / Brand / Non-Preferred		\$10 Copayment / PD + 40% Coins. / PD + 50% Coins. \$25 Copayment / PD + \$125 Copayment / PD + \$200 Copayment
Out-of-Network Prescription Drug Program Retail and Specialty Pharmacy - Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred		50% Coinsurance / PD + 50% Coinsurance 50% Coinsurance / PD + 50% Coinsurance
<p>If you request a Brand Name Prescription Drug when there is a Generic Prescription Drug available, you will be responsible for: 1) the Deductible and the Copayment or Coinsurance applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueScript Pharmacy Program Schedule of Benefits.</p> <p>Your BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Generic Prescription diaphragms and diabetic equipment and supplies.</p>		
<p>► Emergency Medical Care</p>		
Urgent Care Centers In-Network Out-of-Network		CYD + 30% Coinsurance CYD + 50% Coinsurance
Emergency Room Facility Services (ER)⁷ (per visit) In-Network Out-of-Network		CYD + 30% Coinsurance CYD + 50% Coinsurance
Ambulance Services (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network		\$5,000 In-Network CYD + 30% Coinsurance
<p>► Outpatient Diagnostic Services</p>		
Independent Diagnostic Testing Facility Services⁸ (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (Except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network		\$75 Copayment \$250 Copayment CYD + 50% Coinsurance
Independent Clinical Lab⁸ (e.g. blood work) In-Network / Out-of-Network		\$ 0 Copayment / CYD + 50% Coinsurance
Outpatient Hospital Facility Services⁷ (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network		CYD + 30% Coinsurance CYD + 50% Coinsurance
<p>► Mental Health/Substance Dependency</p>		
Mental Health (Inpatient PCY / Outpatient PCY / Lifetime Maximum) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network		\$2,000 / \$600 / \$10,000 CYD + 30% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance CYD + 30% Coinsurance CYD + 50% Coinsurance
Substance Dependency (Lifetime max) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network		\$2,000 CYD + 30% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance CYD + 30% Coinsurance CYD + 50% Coinsurance

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Benefits for Covered Services

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► Other Provider Services		
Provider Services at Hospital and ER⁷ In-Network / Out-of-Network		In-Network CYD + 30% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center In-Network / Out-of-Network		In-Network CYD + 30% Coinsurance
Provider Services at Locations other than Office, Hospital and ER⁸ In-Network Family Physician In-Network Specialist Out-of-Network		CYD + 30% Coinsurance CYD + 30% Coinsurance CYD + 50% Coinsurance
► Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max) In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network		\$1,500 CYD + 30% Coinsurance CYD + 50% Coinsurance \$55 Copayment / \$70 Copayment CYD + 50% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics⁷ In-Network Out-of-Network		CYD + 30% Coinsurance CYD + 50% Coinsurance
Home Health Care (PCY max) In-Network Out-of-Network		\$2,500 CYD + 30% Coinsurance CYD + 50% Coinsurance
Skilled Nursing Facility (PCY max) In-Network Out-of-Network		60 days CYD + 30% Coinsurance CYD + 50% Coinsurance
Hospice (Lifetime max) In-Network Out-of-Network		No Maximum CYD + 30% Coinsurance CYD + 50% Coinsurance
► Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC)⁸ In-Network / Out-of-Network		\$200 Copayment / CYD + 50% Coinsurance
Provider Services Rendered at an ASC⁸ In-Network Family Physician In-Network Specialist Out-of-Network		CYD + 30% Coinsurance CYD + 30% Coinsurance CYD + 50% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services⁷(per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network		Rehabilitation limit PCY - 21 days CYD + 30% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance
Outpatient Hospital Facility Services⁸ (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All Other Services (Option 1 / Option 2) Out-of-Network Facility		\$55 Copayment / \$70 Copayment CYD + 30% Coinsurance CYD + 50% Coinsurance
Emergency Room Facility Services (ER)⁷ (per visit) In-Network Out-of-Network		CYD + 30% Coinsurance CYD + 50% Coinsurance

⁷ Includes services rendered at a Hospital, Psychiatric Facility or Substance Abuse Facility. Please refer to the Provider Directory to determine the applicable option for each In-Network Hospital. Services rendered at an Out-of-State BlueCard[®] Program participating hospital are at the Option 2 In-Network cost sharing amount.

⁸ Includes services rendered at locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or a Physician's Office.

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► Financial Features	
Calendar Year Deductible (CYD) (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	\$2,500 / N/A \$4,500 / \$7,500
Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	\$500
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	30% / 50%
Out-of-Pocket Maximum (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD; Excludes Prescription Drugs. The In-Network Out-of-Pocket Maximum and Out-of-Network Out-of-Pocket Maximum are separate, and as such, accumulate separately and are applied separately.) (Any non-covered charges, benefit penalty reductions, charges in excess of any maximum benefit limitations, or charges in excess of the Allowed Amount are not included.)	\$6,000 / \$12,000 \$25,000 / \$25,000
Total Lifetime Maximum Benefit (per member)	\$5,000,000

Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual BlueOptions Contract. For a complete listing, please refer to the Contract.

- All services not specifically listed in the Contract or in any rider or endorsement, unless such services are specifically required by state law
- Any service which is not Medically Necessary
- Maternity care
- Elective cosmetic surgery
- Hearing aids or eyeglasses, vision or dental care, or oral appliances
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual BlueOptions Contract for details. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract. For a complete description of benefits and exclusions, please see the Contract.