



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. Plus, the plan comes with benefits for routine dental care.

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

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 \$50 Copayment CYD ³ + 50% Coinsurance ⁴ \$10 Copayment CYD + 50% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network	\$200 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 \$10 Copayment 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 \$50 Copayment 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 \$50 Copayment 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 \$50 Copayment 50% Coinsurance

1 Policies have limitations and exclusions and are medically underwritten.

2 NetworkBlue 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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Prescription Drug Program (BlueScript)®	
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.	
Pharmacy Deductible (PD)	\$0
In-Network Prescription Drug Program Retail and Specialty Pharmacy – Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred	\$10 Copayment / Not Covered \$25 Copayment / Not Covered
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 / Not Covered 50% Coinsurance / Not Covered
BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Generic Prescription diaphragms and diabetic equipment and supplies.	
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	\$55 Copayment CYD + 50% Coinsurance
Emergency Room Facility Services (ER)⁷ (per visit) In-Network Out-of-Network	\$300 Copayment \$300 Copayment
Ambulance Services (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network	\$5,000 In-Network CYD + 25% Coinsurance
Outpatient Diagnostic Services	
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	\$50 Copayment \$200 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 + 25% Coinsurance CYD + 50% Coinsurance
Mental Health/Substance Dependency	
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 + 25% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance \$50 Copayment 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	\$2,500 CYD + 25% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance \$50 Copayment CYD + 50% Coinsurance

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Other Provider Services	
Provider Services at Hospital and ER⁷ In-Network / Out-of-Network	In-Network CYD + 25% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center In-Network / Out-of-Network	In-Network CYD + 25% Coinsurance
Provider Services at Locations other than Office, Hospital and ER⁸ In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 25% Coinsurance CYD + 25% 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	\$2,500 CYD + 25% Coinsurance CYD + 50% Coinsurance CYD + 25% Coinsurance CYD + 50% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics⁷ In-Network Out-of-Network	CYD + 25% Coinsurance CYD + 50% Coinsurance
Home Health Care (PCY max) In-Network Out-of-Network	\$1,000 CYD + 25% Coinsurance CYD + 50% Coinsurance
Skilled Nursing Facility (PCY max) In-Network Out-of-Network	60 days CYD + 25% Coinsurance CYD + 50% Coinsurance
Hospice (Lifetime max) In-Network Out-of-Network	No Maximum CYD + 25% Coinsurance CYD + 50% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)⁸ In-Network / Out-of-Network	CYD + 25% Coinsurance / CYD + 50% Coinsurance
Provider Services Rendered at an ASC⁸ In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 25% Coinsurance CYD + 25% 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 + 25% 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 + 25% Coinsurance CYD + 50% Coinsurance
Emergency Room Facility Services (ER)⁷ (per visit) In-Network Out-of-Network	\$300 Copayment \$300 Copayment

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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Benefits for Covered Services

Amount Member Pays

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)	\$3,000 / N/A \$6,000 / N/A
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)	25% / 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.)	\$7,500 / \$15,000 \$25,000 / \$25,000
Total Lifetime Maximum Benefit (per person)	\$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.

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Benefits for Covered Services

Amount Member Pays

Understanding Your Share for Covered Dental Expenses

Dental Services	
Calendar Year Deductible ¹⁰ (per person/family aggregate) In-Network ⁹ and Out-of-Network	Basic Services only \$75 / \$225
Preventive Services In-Network ⁹ and Out-of-Network (Including Periodic oral evaluation, Bitewings—two films, Cleaning—Adult/Child, Fluoride Treatment (Child only)	No Waiting Period \$0
Basic Services In-Network ⁹ and Out-of-Network (Including Amalgam Restorations (Silver fillings), Extractions—Routine and Surgical, Intraoral—complete series (including bitewings), Resin— based composite one surface, posterior	No Waiting Period CYD + 20% Coinsurance ¹¹
Plan Year Maximum Benefits ¹⁰ (per member)	\$750

Dental Limitations and Exclusions

Limitations:

- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- Sealants are limited to the first and second molars for primary teeth and the bicuspid and molars for the permanent teeth of covered dependent children.
- Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.

Exclusions:

- Veneer restorations
- Services rendered primarily for cosmetic purposes
- General anesthesia and intravenous sedation
- Charges for nitrous oxide
- Implant services
- Major services including, but not limited to, dentures (full, partial and replacement), bridges (including pontics, and abutment crowns—new or replacement), inlays and onlays, partials (new or replacement)
- Orthodontia services

⁹ Networks are comprised of independent contracted dentists.

¹⁰ CYD and maximum benefits for Dental Services are separate from Health Services CYD and maximum benefits, and as such accumulates separately.

¹¹ Coinsurance is the percentage of the Fee Schedule the member pays for services.