BlueOptions

Schedule of Benefits – Plan 03359

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period.....**01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$1,000	$2,000
Per Family per Benefit Period	$3,000	$6,000
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	40%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$3,000	$5,000
Per Family per Benefit Period	$6,000	$10,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office visits and Services not otherwise outlined in this table rendered by Family Physicians	$25	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	$125	DED + 40%
Other health care professionals licensed to perform such Services	$125	DED + 40%
Allergy Injections rendered by Family Physicians	$10	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
E-Visits rendered by Family Physicians	$10	DED + 40%
Other health care professionals licensed to perform such Services	$10	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 40%
Convenient Care Centers	$25	DED + 40%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by:		
Family Physicians	20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	20%	DED + 50%
Out-of-Pocket Maximum per Person per Month	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Adult Well Woman Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$125	DED + 40%
All other diagnostic Services (e.g., X-rays)	$50	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 20%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 20%	DED + 20%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	$100	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	In-Network DED + 20%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	$750	$1,000	**DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Outpatient			
Facility (per visit)	$150	$250	DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Therapy Services	$45	$60	DED + 40%
Emergency Room Visits			
Facility	$200 (Copayment waived if admitted)		$200
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and Emergency Room Copayment will apply to that admission.

Important:

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. This Plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room (Per Visit Deductible) (PVD)	$50 PVD + $100	$50 PVD + $100
Hospital a) Option 1	$150	DED + 40%
Option 2 and Out-of-State BlueCard® Participating	$250	DED + 40%
Physician Services at Hospital and ER	DED + 20%	In-Network DED + 20%
Physician and other health care professionals licensed to perform such Services Family Physician office	$25	DED + 40%
Specialist office	DED + 20%	DED + 40%
All other locations	DED + 20%	DED + 40%
Inpatient Facility Services a) Option 1	$750	DED + 40%
b) Option 2 and Out-of-State BlueCard® Participating	$1,000	DED + 40%
Physician and other health care professionals licensed to perform such Services	DED + 20%	In-Network DED + 20%

Benefit Maximums

Home Health Care Visits per Benefit Period..... 20

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility days per Benefit Period..... 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

Prescription Drug Program

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.

BlueScript® Pharmacy Program

Schedule of Benefits

You should carefully review this Pharmacy Program Schedule of Benefits. If you did not receive, or cannot find, the BlueScript Pharmacy Program Endorsement, which this Pharmacy Program Schedule of Benefits is a part of, contact us to obtain one. To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on your Identification Card. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

	Participating Pharmacy	**Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	$10	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$10	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$20	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs or Supplies purchased at:		
Retail Pharmacy – For up to a One-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$120	50% of the Non-Participating Pharmacy Allowance

Other Important Information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide; Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**

  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.