Annual Open Enrollment

2019 Group Health Benefits Guide

CALHOUN COUNTY
SCHOOL DISTRICT

Darryl Taylor, Jr.
Superintendent of Schools

Last Day of Open Enrollment
August 16, 2019

Welcome from Benefits Management

Greetings Fellow Calhoun County School District Employee:

It is my pleasure to welcome you to the 2019 Open Enrollment for Group Health Benefits. The Annual Open Enrollment period is your once-a-year opportunity to make changes to your current benefit election and to review your covered dependents. The plan year for medical benefits begins on October 2019 and continues through September 30, 2020. Health benefit elections made during Open Enrollment are generally binding for the entire plan year.

Calhoun County School District is committed to providing high quality benefits from you and your family. The diligent efforts of the Superintendent of Schools, School Board Members, Association of Calhoun Educators (ACE), and your Insurance Committee continue to demonstrate the results of an excellent partnership. Your benefits are a valuable part of your employment with the Calhoun County School District. Be sure you are making the most of them!

Open Enrollment of Dental and Vision Benefits will be in November with an effective date of January 1, 2020. Enrollment in the Flexible Spending Account (FSA), better known as the Cafeteria Plan or TASC Card will also be in November with an effective date of January 1, 2020.

Representatives from Liberty National, Colonial Insurance, and AFLAC will be available at Blountstown High School on August 5, 2019. You will be able to make plan changes at this time, but no later than August 16, 2019.

The enclosed 2019 Medical Benefits Guide includes a summary of your benefit plans, the eligibility requirements and instructions on how to enroll. The guide will be available through the Calhoun County School District website at www.calhounflschools.org.

What Should I Do?

1 Review this Booklet

Open Enrollment is your one-time opportunity to review your current medical benefit elections and make any changes that may be needed for you and your family. Please take the time to familiarize yourself with the guide's contents. We hope that after your review this guide you will have a clear understanding of the changes that will be effective October 1, 2019 and how they may impact you and your covered dependents. You are important! That's why we work hard to provide you with affordable benefit options for you and your family.

2 Make 2019 Elections

Forms included in this booklet must be returned to Rhonda O'Bryan by August 16, 2019. Representatives from the Benefits Office will be present at your school on the following days to assistant you with enrollment, answer any questions, and collect completed forms:

Altha Public School: 8/13 2:30-4:00 & 8/16 7:00-4:00

BES- 8/14 7:00-4:00

Carr Elementary & Middle School: 8/13 7:00-1:30

BHS 8/15 7:00-4:00

Bus/Maintenance Shop: 8/9 7:00-8:45

CARE/ALC/Adult/Special Programs:8/9 9:00-11:00

3 What if I want to make no changes to plan?

If you do not wish to make any changes to your plan, please select no changes on the enrollment form, sign and return your form along with dependent eligibility documentation to Rhonda O'Bryan through the County Mail, email, fax, or mail.

4 What if I don't want to return my form?

If you do not complete your enrollment form and return it to Rhonda O'Bryan by August 16, 2019, your benefits **will remain the same** as your previous year's election.

5 What if I want to waive the medical insurance?

If you are covered by another medical plan and do not wish to enroll with the Calhoun County School District, please check the box to wave coverage and return the form to Rhonda O'Bryan.

Who is Eligible?

Employees

Employees who work at least 20 hours per week and have completed the necessary waiting period, including those active employees eligible for coverage under Medicare are eligible for benefits.

Spouses

Spouses are eligible for coverage when they met all requirements of a legal marriage in the state of Florida. An ex-spouse does not meet eligibility criteria even if insurance coverage is specified by a judge in a divorce decree.

If you and your spouse are both employees and eligible for coverage, you will both receive the full board contribution for your coverage.

Children

A covered employee's children are eligible for coverage until the end of the calendar month in which they turn 26. An eligible child includes the employee's natural born, adopted, foster, or step child(ren), and a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian.

There are provisions for continuing coverage for dependent children beyond the age of 26. If you feel you have a dependent who may meet this criteria and have not already submitted documentation to the Benefits Office, please contact Rhonda O'Bryan at 850-674-5927 ext 30 so that she can assist you with this process.

Grandchildren can only be covered up to 18 months of age and are only eligible if the parent remains covered.

Eligibility Documentation

It is your responsibility to show that your dependent meets the eligibility requirements and to remove them when eligibility ends. Eligibility ends on the last day of the month in which the requirements are no longer met. The premium will be deducted for the entire plan year; however, dependents will not be covered until documentation is received. **All covered employees must provide the following documentation to the Benefits Department for any covered dependent by the end of the open enrollment period.**

Dependent Relationship	Documentation Requirements*	
Spouse	Copy of Marriage License	
Natural Child	Copy of Birth Certificate (must list employee as a parent)	
Step Child	Copy of Birth Certificate (must list employee's spouse as a parent) and Marriage License	
Adopted Child	Adoption Certificate	
Legal Custody or Guardianship	Court Order establishing legal guardianship	
Disable Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by the Calhoun County School District Health Plan prior to age 26.	
Adult Child (ages 19-26)	Copy of Birth Certificate	
Grandchildren (EE's child must be listed as parent on birth certificate and remain covered)	UNDER 19 MONTHS OLD Copy of Birth Certificate	OVER 18 MONHS OLD Legal Custody or Guardianship documentation

*The previous year's U.S. Tax Return showing you claimed the dependent can also be used to establish eligibility.

Premium Information

Payroll Deductions

Premiums are due in advance: therefore deductions begin one month before coverage is effective. Deductions for October 1, 2019 coverage will be taken from your September paycheck. Be sure to check both your paycheck to ensure 2019 elections are correct.

When will your insurance end?

For 9 and 10 month employees: If you work to the end of the contract year, your benefits will end on September 30, 2020. If you resign prior to the end of the school year your benefits will end the last day of the month in which you paid for coverage from your last paycheck.

For 12 month employees: Your benefits will end the last day of the month in which you pay for coverage from your last paycheck.

What is the amount of the Board Contribution?

The Calhoun County School Board contributes $448.59 per month for health insurance for each eligible employee.

What is a Life Status Change?

A Life Status Change is an event recognized as qualifying an employee to make changes in benefit selections at a time other than an Annual Enrollment Period. **Any request to make changes in benefit selections must be submitted in writing within 30 days of any applicable event.** The following events are Life Status Changes.

- Marriage
- Divorce, annulment or legal separation
- Birth or adoption of a child
- Death of a spouse
- Termination of a spouse's employment
- Enrollment in Medicare or Medicaid
- A change in the benefit plan available to the Employee's spouse
- A change in the Employee's or his or her spouse's employment status that affects either person's eligibility for benefits
- A loss of health coverage through another provider, proof of prior coverage is required.

What about basic life insurance?

All regularly employed employees receive $20,000 of term life insurance at no cost to them. Employees 65 or over receive a decreased value. Once an employee reaches age 65; the value of the life insurance decreases and continues to decrease every 5 years thereafter.

What does self-insured mean?

Being self-insured means that the District sets aside a pool of money to pay the insurance claims for all of its employees. Any time you pay premiums (payroll deductions) for coverage, it goes into this pool along with the District's money. The District then uses this money to pay a share of your costs for health services.

So the less money we pay to doctors and other health care providers and prescriptions, the less money the District spends. That means it pays to shop around and always use network providers. Many organizations with group health insurance plans are fully insured rather than self-insured. However, being self-insured allows us to save our employees money by keeping health insurance premiums lower.

What health insurance plans are offered?

Calhoun County School Board offers four (4) health plans to choose from through Blue Cross and Blue Shield of Florida., known as Florida Blue.

Florida Blue

A full Summary of Benefits and Coverage can be viewed at www.calhounflschools.org

You can also call 1-800-352-2583 or visit www.floridablue.com

All forms must be returned to Rhonda O'Bryan, Benefits by August 16, 2019 by:

County Mail:
Give to your school secretary

FAX:
850-674-5814

Email:
rhonda.obryan@calhounflschools.org

Mail:
Calhoun County School District
Attn: Rhonda O'Bryan
20859 Central Ave. East, Room G-20
Blountstown, FL 32424

Reminder

Deductions for October 1, 2019 coverage will be taken from your September paycheck. Be sure to check your paycheck to ensure 2019 elections are correct.

For additional assistance please contact Rhonda O'Bryan at:

Phone:
850-674-5927 ext 30

Email:
rhonda.o'bryan@calhounflschools.org

Plan 0727 - $500 Deductible (004)	Group	19/20 Employee Cost
Individual - age 64 and under	B7505004	442.65
1 Dependent - age 64 and under	B7505004	1,252.36
Family	B7505004	1,725.48
Family (2 Employees)	B7505004	1,276.89

Plan 03359 - $1,000 Deductible (001)	Group	19/20 Employee Cost
Individual - age 64 and under	B7505001	313.80
1 Dependent - age 64 and under	B7505001	1,035.04
Family	B7505001	1,456.24
Family (2 Employees)	B7505001	1,007.65

Plan 0117 - $1,500 Deductible (003)	Group	19/20 Employee Cost
Individual - age 64 and under	B7505003	192.63
1 Dependent - age 64 and under	B7505003	796.54
Family	B7505003	1,150.42
Family (2 Employees)	B7505003	701.83

Plan 05901 - $2,000 Deductible (002)	Group	19/20 Employee Cost
Individual - age 64 and under	B7505002	98.00
1 Dependent - age 64 and under	B7505002	653.60
Family	B7505002	979.17
Family (2 Employees)	B7505002	530.58

Florida Blue
In the pursuit of health®

Know Before You Go -

Urgent Care vs. Emergency Room

URGENT CARE CENTER	EMERGENCY ROOM
Cold, flu, or fever	Chest pain
Strains, sprains, or breaks	Abdominal pain
Infections	Stroke
Mild burns	Severe head injury
Allergies	Major trauma

71% of emergency department visits are unnecessary or could have been avoided.[1]

LOWER copay applies[2]

HIGHER copay applies[2]

You will usually be seen in under **20** minutes

Average length of time spent in the ER nationwide[3]
2 hours **15** minutes

EXTENDED HOURS
OPEN
WEEKENDS

Open 24/7

If you have a life-threatening illness or injury, go to the ER or call 911 right away.

BlueChoice

Schedule of Benefits - Plan 0727

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- References to Deductible are abbreviated as "**DED**" and references to Benefit Period are abbreviated as "**BP**".

Your Benefit Period (BP) ..... **01/01 – 12/31**

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Deductible (DED) - Embedded* Per Person per BP	$500	Combined with INN
Per Family per BP	$1,000	Combined with INN
Per Admission Deductible (PAD)	$0	$0
Emergency Room Per Visit Deductible (PVD)	$0	$0
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	40%
Out-of-Pocket Maximums - Embedded* Per Person per BP	$2,000	Combined with INN
Per Family per BP	$4,000	Combined with INN

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.

*Refer to the YOUR SHARE OF HEALTH CARE EXPENSES section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Out-Of-Pocket Maximums amounts are satisfied.

What **applies** to out-of-pocket maximums?

- Copayments
- Coinsurance
- DED
- PAD, if applicable
- PVD, if applicable
- Any Prescription Drug Cost Share amounts

What **does not apply** to out-of-pocket maximums?

- Charges for non-covered Services
- Charges in excess of the Allowed Amount
- Any benefit penalty reductions

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 Copay is listed in the charts that follow, the Copay applies per visit.

OFFICE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Office Visits rendered by Primary Care Physicians	DED + 20%	DED + 40%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Allergy Injections rendered by Primary Care Physicians	$5 Copay	DED + 40%
Specialist Physicians and 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 medicine) **rendered by** Primary Care Physicians	DED + 20%	DED + 40%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 40%

OFFICE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
E-Visits rendered by Primary Care Physicians	DED + 20%	DED + 40%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Outpatient Therapies and Spinal Manipulation rendered by Primary Care Physicians	DED + 20%	DED + 40%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 40%

MEDICAL PHARMACY	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Prescription Drugs administered in the office	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 and Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.

PREVENTIVE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Adult Wellness Services rendered by Primary Care Physicians	$0 Copay	40%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	40%
All other locations	$0 Copay	40%
Adult Well Woman Services rendered by Primary Care Physicians	$0 Copay	40%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	40%
All other locations	$0 Copay	40%
Child Health Supervision Services rendered by Primary Care Physicians	$0 Copay	40%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	40%
All other locations	$0 Copay	40%
Colonoscopies (Routine)	$0 Copay	40%
Mammograms	$0 Copay	$0 Copay

OUTPATIENT DIAGNOSTIC SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Independent Clinical Lab	DED + 20%	DED + 40%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 20%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 20%	DED + 40%
Outpatient Hospital Facility	DED + 20%	DED + 40%

EMERGENCY AND URGENT CARE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulance Services	DED + 20%	DED + 20%
Convenient Care Centers	DED + 20%	DED + 40%
Emergency Room Visits Facility	DED + 20%	DED + 20%
Physician Services	DED + 20%	DED + 20%
Urgent Care Center	DED + 20%	DED + 20%

OUTPATIENT SURGICAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulatory Surgical Center Facility (per visit)	DED + 20%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	DED + 40%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 40%
Outpatient Hospital Facility	DED + 20%	DED + 40%

HOSPITAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Facility Services (per admission)	DED + 20%	*DED + 40%
Physician and other health care professional Services	DED + 20%	DED + 20%
Outpatient Facility (per visit)	DED + 20%	DED + 40%
Physician and other health care professional Services	DED + 20%	DED + 20%
Therapy Services	DED + 20%	DED + 40%
Emergency Room Visits Facility	DED + 20%	DED + 20%
Physician and other health care professional Services	DED + 20%	DED + 20%

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. Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) will be covered at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

*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 In-Network Coinsurance will apply to that admission.

MENTAL HEALTH SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	DED + 20%	DED + 40%
Outpatient Facility Services rendered at Emergency Room	DED + 20%	DED + 20%
Hospital, Psychiatric or Substance Abuse Facility	DED + 20%	DED + 40%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	DED + 20%	DED + 40%
Specialist Office	DED + 20%	DED + 40%
Emergency Room	DED + 20%	DED + 20%
Hospital, Psychiatric or Substance Abuse Facility	DED + 20%	DED + 20%
Primary Care Physician at all other locations	DED + 20%	DED + 40%
Specialist at all other locations	DED + 20%	DED + 40%

SUBSTANCE DEPENDENCY SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	DED + 20%	DED + 40%
Outpatient Facility Services rendered at Emergency Room	DED + 20%	DED + 20%
Hospital, Psychiatric or Substance Abuse Facility	DED + 20%	DED + 40%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	DED + 20%	DED + 40%
Specialist Office	DED + 20%	DED + 40%
Emergency Room	DED + 20%	DED + 20%
Hospital, Psychiatric or Substance Abuse Facility	DED + 20%	DED + 20%
Primary Care Physician at all other locations	DED + 20%	DED + 40%
Specialist at all other locations	DED + 20%	DED + 40%

OTHER SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Birth Center	DED + 20%	DED + 40%
Dialysis Center	DED + 20%	DED + 40%
Durable Medical Equipment	DED + 20%	DED + 40%
Enteral Formula	DED + 20%	DED + 40%
Home Health Services	$0 Copay	$0 Copay
Hospice Services - Inpatient, Outpatient and Home	DED + 20%	DED + 40%
Outpatient Rehabilitation Facility	DED + 20%	DED + 40%
Prosthetic and Orthotic Devices	DED + 20%	DED + 40%
Skilled Nursing Facility	$0 Copay	$0 Copay

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits 58

Outpatient Therapies and Spinal Manipulation visits (combined) 75

Skilled Nursing Facility days 120

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 Florida Blue or Florida Blue HMO to the Group, amounts applied to your Benefit Period maximums under the prior Florida Blue or Florida Blue HMO policy will be applied toward your Benefit Period maximums under this plan.

ADDITIONAL BENEFITS/FEATURES

Deductible Carry-over

Any amounts credited by us toward your individual Deductible on claims for Covered Services incurred during the last three months of the prior Benefit Period will be carried over to reduce your individual Deductible requirement for the current Benefit Period.

BlueScript® Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the Pharmacy Program described in the PRESCRIPTION DRUG PROGRAM section of your Benefit Booklet, both of which should be reviewed carefully. For a list of In-Network Pharmacies, you may contact our local office or access the most recent provider directory at www.floridablue.com.

Amounts listed below are the Cost Share amounts **you pay**.

BENEFIT DESCRIPTION	IN-NETWORK (INN) PHARMACY	OUT-OF-NETWORK (OON) PHARMACY
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased from:		
Retail Pharmacy – For up to a One-Month Supply	$5 Copay	50%
Specialty Pharmacy - For up to a One-Month Supply	$5 Copay	50%
Mail Order Pharmacy – For up to a Three-Month Supply	$10 Copay	50%
Preferred Brand Name Prescription Drugs and Supplies purchased from:		
Retail Pharmacy – For up to a One-Month Supply	$30 Copay	50%
Specialty Pharmacy - For up to a One-Month Supply	$30 Copay	50%
Mail Order Pharmacy – For up to a Three-Month Supply	$60 Copay	50%
Non-Preferred Prescription Drugs and Supplies purchased from:		
Retail Pharmacy – For up to a One-Month Supply	$60 Copay	50%
Specialty Pharmacy - For up to a One-Month Supply	$60 Copay	50%
Mail Order Pharmacy – For up to a Three-Month Supply	$120 Copay	50%

Other Important Information affecting the amount you will pay:

- 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.

  Note: The difference in cost described in 2 above is a benefit penalty and therefore does not help to satisfy your Deductible or Out-of-Pocket Maximums.

- Specialty Drugs are only covered when purchased from the Specialty Pharmacy and only up to a One-Month Supply.

- 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 get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) from a retail In-Network Pharmacy, if the Prescription is written for a Three-Month Supply. 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.

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.

BlueOptions

Schedule of Benefits – Plan 05901

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	$2,000	$6,000
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	50%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$6,350	$30,000
Per Family per Benefit Period	$12,700	$30,000

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 rendered by		
Family Physicians	$35	DED + 50%
Other health care professionals licensed to perform such Services	$75	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$200	DED + 50%
Other health care professionals licensed to perform such Services	$200	DED + 50%
Allergy Injections rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
E-Visits rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 50%	DED + 50%
Convenient Care Centers	$35	DED + 50%

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		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$200	DED + 50%
All other diagnostic Services (e.g., X-rays)	$50	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 50%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 50%	DED + 50%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	DED + 50%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	DED + 50%	In-Network DED + 50%
Other health care professional Services rendered by all other Providers	DED + 50%	DED + 50%
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)	$2,000	$3,000	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Outpatient Facility (per visit)	$300	$400	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Therapy Services	$80	$90	DED + 50%
Emergency Room Visits Facility	DED + 50%		DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%

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

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	$0	$0
Hospital	$0	50%
Physician Services at Hospital and ER	**$0**	**$0**
Physician and other health care professionals licensed to perform such Services		
Family Physician office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient		
Facility Services	$0	50%
Physicians and other health care professionals licensed to perform such Services	$0	$0

Benefit Maximums

Home Health Care Visits per Benefit Period..... 10

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

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 25

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	$15	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$15	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$40	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	$50	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$125	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	$80	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$80	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$200	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.

BlueChoice

Schedule of Benefits - Plan 0117

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- References to Deductible are abbreviated as "**DED**" and references to Benefit Period are abbreviated as "**BP**".

Your Benefit Period (BP) ..... **01/01 – 12/31**

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Deductible (DED) - Embedded* Per Person per BP	$1,500	Combined with INN
Per Family per BP	$4,500	Combined with INN
Per Admission Deductible (PAD)	$150	$300
Emergency Room Per Visit Deductible (PVD)	$50	$50
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	30%	50%
Out-of-Pocket Maximums - Embedded* Per Person per BP	$5,000	Combined with INN
Per Family per BP	$13,200	Combined with INN

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.

*Refer to the YOUR SHARE OF HEALTH CARE EXPENSES section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Out-Of-Pocket Maximums amounts are satisfied.

What **applies** to out-of-pocket maximums?

- Copayments
- Coinsurance
- DED
- PAD, if applicable
- PVD, if applicable
- Any Prescription Drug Cost Share amounts

What **does not apply** to out-of-pocket maximums?

- Charges for non-covered Services
- Charges in excess of the Allowed Amount
- Any benefit penalty reductions

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 Copay is listed in the charts that follow, the Copay applies per visit.

OFFICE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Office Visits rendered by Primary Care Physicians	DED + 30%	DED + 50%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%
Allergy Injections rendered by Primary Care Physicians	DED + 30%	DED + 50%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) **rendered by** Primary Care Physicians	DED + 30%	DED + 50%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%

OFFICE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
E-Visits rendered by Primary Care Physicians	DED + 30%	DED + 50%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%
Outpatient Therapies and Spinal Manipulation rendered by Primary Care Physicians	DED + 30%	DED + 50%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 30%	DED + 50%

MEDICAL PHARMACY	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Prescription Drugs administered in the office	30%	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 and Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.

PREVENTIVE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Adult Wellness Services rendered by Primary Care Physicians	$0 Copay	50%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	50%
All other locations	$0 Copay	50%
Adult Well Woman Services rendered by Primary Care Physicians	$0 Copay	50%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	50%
All other locations	$0 Copay	50%
Child Health Supervision Services rendered by Primary Care Physicians	$0 Copay	50%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	50%
All other locations	$0 Copay	50%
Colonoscopies (Routine)	$0 Copay	50%
Mammograms	$0 Copay	$0 Copay

OUTPATIENT DIAGNOSTIC SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Independent Clinical Lab	DED + 30%	DED + 50%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 30%	DED + 50%
All other diagnostic Services (e.g., X-rays)	DED + 30%	DED + 50%
Outpatient Hospital Facility	DED + 30%	DED + 50%

EMERGENCY AND URGENT CARE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulance Services	DED + 30%	DED + 30%
Convenient Care Centers	DED + 30%	DED + 50%
Emergency Room Visits Facility	PVD + DED + 30%	PVD + DED + 30%
Physician Services	DED + 30%	DED + 30%
Urgent Care Center	DED + 30%	DED + 30%

OUTPATIENT SURGICAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulatory Surgical Center Facility (per visit)	DED + 30%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	DED + 30%	DED + 50%
Other health care professional Services rendered by all other Providers	DED + 30%	DED + 50%
Outpatient Hospital Facility	DED + 30%	DED + 50%

HOSPITAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Facility Services (per admission)	PAD + DED + 30%	PAD + DED + 50%
Physician and other health care professional Services	DED + 30%	DED + 30%
Outpatient Facility (per visit)	DED + 30%	DED + 50%
Physician and other health care professional Services	DED + 30%	DED + 30%
Therapy Services	DED + 30%	DED + 50%
Emergency Room Visits Facility	PVD + DED + 30%	PVD + DED + 30%
Physician and other health care professional Services	DED + 30%	DED + 30%

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. Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) will be covered at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

*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 In-Network Coinsurance and Emergency Room PVD will apply to that admission.

MENTAL HEALTH SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	PAD + DED + 30%	PAD + DED + 50%
Outpatient Facility Services rendered at Emergency Room	PVD + DED + **3**0%	PVD + DED + 30%
Hospital, Psychiatric or Substance Abuse Facility	DED + 30%	DED + 50%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	DED + 30%	DED + 50%
Specialist Office	DED + 30%	DED + 50%
Emergency Room	DED + 30%	DED + 30%
Hospital, Psychiatric or Substance Abuse Facility	DED + 30%	DED + 30%
Primary Care Physician at all other locations	DED + 30%	DED + 50%
Specialist at all other locations	DED + 30%	DED + 50%

SUBSTANCE DEPENDENCY SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	PAD + DED + 30%	PAD + DED + 50%
Outpatient Facility Services rendered at Emergency Room	PVD + DED + **3**0%	PVD + DED + 30%
Hospital, Psychiatric or Substance Abuse Facility	DED + 30%	DED + 50%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	DED + 30%	DED + 50%
Specialist Office	DED + 30%	DED + 50%
Emergency Room	DED + 30%	DED + 30%
Hospital, Psychiatric or Substance Abuse Facility	DED + 30%	DED + 30%
Primary Care Physician at all other locations	DED + 30%	DED + 50%
Specialist at all other locations	DED + 30%	DED + 50%

OTHER SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Birth Center	DED + 30%	DED + 50%
Dialysis Center	DED + 30%	DED + 50%
Durable Medical Equipment	DED + 30%	DED + 50%
Enteral Formula	DED + 30%	DED + 50%
Home Health Services	DED + 30%	DED + 50%
Hospice Services - Inpatient, Outpatient and Home	DED + 30%	DED + 50%
Outpatient Rehabilitation Facility	DED + 30%	DED + 50%
Prosthetic and Orthotic Devices	DED + 30%	DED + 50%
Skilled Nursing Facility	DED + 30%	DED + 50%

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits 10

Outpatient Therapies and Spinal Manipulation visits (combined) 15

Skilled Nursing Facility days 60

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 Florida Blue or Florida Blue HMO to the Group, amounts applied to your Benefit Period maximums under the prior Florida Blue or Florida Blue HMO policy will be applied toward your Benefit Period maximums under this plan.

BlueScript® Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the Pharmacy Program described in the PRESCRIPTION DRUG PROGRAM section of your Benefit Booklet, both of which should be reviewed carefully. For a list of In-Network Pharmacies, you may contact our local office or access the most recent provider directory at www.floridablue.com.

Amounts listed below are the Cost Share amounts **you pay**.

BENEFIT DESCRIPTION	IN-NETWORK (INN) PHARMACY	OUT-OF-NETWORK (OON) PHARMACY
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased from: **Retail Pharmacy** – For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50%
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50%
Mail Order Pharmacy – For up to a Three-Month Supply	$14 Copay	50%
Preferred Brand Name Prescription Drugs and Supplies purchased from: **Retail Pharmacy** – For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50%
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50%
Mail Order Pharmacy – For up to a Three-Month Supply	$40 Copay	50%
Non-Preferred Prescription Drugs and Supplies purchased from: **Retail Pharmacy** – For up to a One-Month Supply	30% of the Participating	50%

BENEFIT DESCRIPTION	IN-NETWORK (INN) PHARMACY	OUT-OF-NETWORK (OON) PHARMACY
	Pharmacy Allowance after DED	
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50%
Mail Order Pharmacy – For up to a Three-Month Supply	100% of the Participating Pharmacy Allowance	50%

Other Important Information affecting the amount you will pay:

- 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.

  Note: The difference in cost described in 2 above is a benefit penalty and therefore does not help to satisfy your Deductible or Out-of-Pocket Maximums.

- Specialty Drugs are only covered when purchased from the Specialty Pharmacy and only up to a One-Month Supply.
- 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 get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) from a retail In-Network Pharmacy, if the Prescription is written for a Three-Month Supply. 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.

GROUP HEALTH INSURANCE OPEN ENROLLMENT INTENT FORM
2019-2020

SECTION ONE

_____
PRINT NAME LEGIBLY

_____ DATE OF HIRE
Required by Blue Cross

_____ WORK LOCATION
BHS, Altha, District, etc.

CURRENT LEVEL OF COVERAGE: **(Circle One)**
Employee Only One Dependent Family N/A

CURRENT AMOUNT OF DEDUCTIBLE: **(Circle one)**
$500 (0727) $1000 (03359) $1500 (0117) $2000 (05901) N/A

SECTION TWO

I am not making any changes to my current group health insurance participation whether I am enrolled or not. I understand that by signing below, unless I experience a qualifying event, I will not be able to enroll in group health insurance until the next open enrollment period. I also understand that I cannot change from one group health plan to another until the next open enrollment period regardless of a qualifying event.**

*(**A qualifying event includes but is not limited to a change in marital status, loss of dependent eligibility, change of employment status of employee or spouse, FMLA, court order, loss of other coverage)*

_____ **SIGNATURE** _____ **DATE**

SECTION THREE

By signing Section Two you have indicated that you are making no changes to your current enrollment status. DO NOT complete Section Four. Your open enrollment is complete. Please turn in your enrollment intent form as soon as possible. **DO NOT SIGN SECTION FOUR.**

If you are making any type of change or enrolling for the first time proceed to Section Four and complete all areas that apply to your enrollment situation. I will follow up with you to complete the necessary paperwork.

SECTION FOUR

A. I am currently covered under one of our group health plans and want to make the following changes:

_____I am adding a dependent or dependent coverage to my current plan
_____I am dropping a dependent or dependent coverage from my current plan
_____I am changing plans from _____ to _____

If you are terminating your group health participation please complete the Waiver.

B. I am enrolling for the first time (Indicate plan and level of coverage)

Plan: 0727 3359 0117 05901

Level of coverage: Employee Only One Dependent Family

Employees enrolling in group health insurance are required to provide date of birth, gender, social security number and relationship to employee for all eligible dependents as well as a copy of marriage license to add their spouse and/or a birth certificate for all dependent children.

_____ **SIGNATURE** _____ **DATE**

Your signature in Section Four indicates that you are making a change to your current enrollment status. I will follow up with you to complete the necessary paperwork.
DO NOT SIGN SECTION TWO.

THIS FORM IS DUE IN THE FINANCE OFFICE NO LATER THAN NOON ON FRIDAY, AUGUST 16