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.