

# BlueOptions

For Individuals Under 65

## Benefit Summary for Health Plan 510



### Understanding Your Share for Covered Services

This health insurance policy<sup>1</sup> has convenient copays for the most commonly used services. The coverage makes it easy to know what you'll have to spend for medical care, no matter what happens.

NetworkBlue<sup>2</sup> is the Preferred Provider Network designated as "In-Network" for BlueOptions.

Benefits for Covered Services	Amount Member Pays
<b>► Office Services</b>	
<b>Physician Office Services</b> In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	\$35 Copayment CYD <sup>3</sup> + 20% Coinsurance <sup>4</sup> CYD + 40% Coinsurance \$10 Copayment CYD + 40% Coinsurance
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network	\$250 Copayment CYD + 40% Coinsurance
<b>Maternity Initial Visit</b> With many plans a maternity option is available – you can choose to add an endorsement, at an additional rate, that provides benefits for pregnancy and delivery (the endorsement must be in effect for 30 days prior to conception).	Available
<b>Allergy Injections</b> (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	\$10 Copayment \$10 Copayment CYD + 40% Coinsurance
<b>Medical Pharmacy - Physician-Administered Medications</b> (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum <sup>5</sup> In-Network Out-of-Network	\$200 20% Coinsurance CYD + 50% Coinsurance
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your <i>medical</i> benefit. <b>Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.</b>	
<b>► Preventive Care</b>	
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b> In-Network Out-of-Network	\$0 40% Coinsurance
<b>Mammograms</b> In-Network and Out-of-Network	\$0
<b>Colonoscopy</b> (Routine for age 50+ then frequency schedule applies) In-Network and Out-of-Network	\$0
<b>► Prescription Drug Program (BlueScript®)</b>	
For the greatest savings on your prescriptions, always check to see if the pharmacy is in-network for your BlueOptions plan. Your medication will cost you less if you stay in-network. We have identified certain drugs as a 'specialty drug'. These drugs are listed as a 'specialty drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy.	
<b>Pharmacy Deductible (PD)</b>	\$1,500 (Brand Only)

1 Policies have limitations and exclusions.

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

3 CYD = Calendar Year Deductible

4 Coinsurance is the percentage the member pays for service.

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

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

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<b>► Prescription Drug Program (BlueScript®) (Continued)</b>	
<b>In-Network Prescription Drug Program</b> Retail and Specialty Pharmacy – Generic / Brand / Non-Preferred Mail Order (90 days) – Generic / Brand / Non-Preferred	\$10 Copayment / PD + 40% Coinsurance / PD + 50% Coinsurance \$25 Copayment / PD + \$125 Copayment / PD + \$200 Copayment
<b>Out-of-Network Prescription Drug Program</b> Retail and Specialty Pharmacy - Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred	50% Coinsurance / PD + 50% Coinsurance 50% Coinsurance / PD + 50% Coinsurance
<p>If you request a Brand Name Prescription Drug when there is a Generic Prescription Drug available, you will be responsible for:</p> <ol style="list-style-type: none"> <li>1) the Deductible and the Copayment or Coinsurance applicable to Brand Name Prescription Drugs; and</li> <li>2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueScript Pharmacy Program Schedule of Benefits. <p><b>Your BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Prescription diaphragms and diabetic equipment and supplies.</b></p> </li></ol>	
<b>► Emergency Medical Care</b>	
<b>Urgent Care Centers</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>6</sup></b> (per visit) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance
<b>Ambulance Services</b> (Ground travel / air and water travel, per day maximum) In-Network and Out-of-Network	\$5,000 In-Network CYD + 20% Coinsurance
<b>► Outpatient Diagnostic Services</b>	
<b>Independent Diagnostic Testing Facility Services<sup>7</sup></b> (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (Except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network	\$75 Copayment \$250 Copayment  CYD + 40% Coinsurance
<b>Independent Clinical Lab<sup>7</sup></b> (e.g. blood work) In-Network Out-of-Network	\$0 CYD + 40% Coinsurance
<b>Outpatient Hospital Facility Services<sup>6</sup></b> (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>► Mental Health/Substance Dependency</b>	
<b>Mental Health</b> (Inpatient PCY <sup>8</sup> / Outpatient PCY) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	8 Days / 8 Visits  CYD + 20% Coinsurance \$500 PAD + CYD + 40% Coinsurance  CYD + 20% Coinsurance CYD + 40% Coinsurance

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

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

8 PCY = Per Calendar Year

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<b>► Mental Health/Substance Dependency (Continued)</b>	
<b>Substance Dependency</b> Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	CYD + 20% Coinsurance \$500 PAD + CYD + 40% Coinsurance  CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>► Other Provider Services</b>	
<b>Provider Services at Hospital and ER<sup>6</sup></b> In-Network and Out-of-Network	In-Network CYD + 20% Coinsurance
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center</b> In-Network and Out-of-Network	In-Network CYD + 20% Coinsurance
<b>Provider Services at Locations other than Office, Hospital and ER<sup>7</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>► Other Special Services</b>	
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)</b> Locations other than Hospital and Physician's Office In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	25 Visits  CYD + 20% Coinsurance CYD + 40% Coinsurance  \$55 Copayment / \$70 Copayment CYD + 40% Coinsurance
<b>Durable Medical Equipment, Prosthetics and Orthotics<sup>6</sup></b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Home Health Care (PCY max)</b> In-Network Out-of-Network	20 Visits CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Skilled Nursing Facility (PCY max)</b> In-Network Out-of-Network	60 days CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Hospice</b> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>► Hospital/Surgical</b>	
<b>Ambulatory Surgical Center Facility (ASC)<sup>7</sup></b> In-Network Out-of-Network	\$200 Copayment CYD + 40% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services<sup>6</sup></b> (per admit) (PCY max) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation limit PCY - 21 days CYD + 20% Coinsurance \$500 PAD + CYD + 40% Coinsurance

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<b>► Hospital/Surgical (Continued)</b>	
<b>Outpatient Hospital Facility Services<sup>7</sup></b> (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All Other Services (Option 1 / Option 2) Out-of-Network Facility	\$55 Copayment / \$70 Copayment CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>6</sup></b> (per visit) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance
<b>► Financial Features</b>	
<b>Calendar Year Deductible (CYD)</b> (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	\$500 / N/A \$1,500 / \$4,500
<b>Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$500
<b>Coinsurance</b> In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	20% / 40%
<b>Out-of-Pocket Maximum</b> (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD; Excludes Prescription Drugs. The In-Network Out-of-Pocket Maximum and Out-of-Network Out-of-Pocket Maximum are separate, and as such, accumulate separately and are applied separately.) (Any non-covered charges, benefit penalty reductions, charges in excess of any maximum benefit limitations, or charges in excess of the Allowed Amount are not included.)	\$4,000 / \$8,000 \$25,000 / \$25,000
<b>Total Lifetime Maximum Benefit</b> (per member)	No Maximum

For added peace of mind, your dependents may be covered as long as you maintain your BlueOptions policy with us. Ask for complete details since some restrictions apply.

### Limitations and Exclusions

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

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

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