BlueOptions

For Individuals Under 65

Benefit Summary for Health Plan 626 for Single Coverage and Health Plan 627 for Family Coverage – *HSA-compatible Plans*

Understanding Your Share for Covered Services

This health insurance policy[1] is designed to be paired with a Health Savings Account (HSA[2]). This plan allows you to use tax-free contributions to help cover out-of-pocket health care expenses, including qualified deductibles, copays and coinsurance. Simple coverage: once you meet the calendar year deductible, you pay only the coinsurance amount when you receive covered services. More good news: there is no deductible to meet for adult wellness and preventive care for children.

NetworkBlue[3] is the Preferred Provider Network designated as "In-Network" for BlueOptions.

Benefits for Covered Services	Amount Member Pays
▶ Office Services	
Physician Office Services	
In-Network Family Physician	CYD[4]
In-Network Specialist	CYD
Out-of-Network Office Visit	CYD + 40% Coinsurance[5]
In-Network e-Office Visit	CYD
Out-of-Network e-Office Visit	CYD + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance
Maternity Initial Visit With many plans a maternity option is available – you can choose to add an endorsement, at an additional rate, that provides benefits for pregnancy and delivery (the endorsement must be in effect for 30 days prior to conception).	Not Available
Allergy Injections (per visit)	
In-Network Family Physician	CYD
In-Network Specialist	CYD
Out-of-Network	CYD + 40% Coinsurance
Medical Pharmacy - Physician-Administered Medications (Applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum	No Maximum
In-Network	CYD
Out-of-Network	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 *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**	
▶ Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	40% Coinsurance
Mammograms	
In-Network and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network and Out-of-Network	$0

1 Policies have limitations and exclusions.
2 BlueCross and BlueShield of Florida (BCBSF) offers only the BlueOptions high-deductible health plans specifically designed to be used in conjunction with a Health Savings Account (HSA). For more information on the tax advantages and implications of HSAs as used with a high-deductible health plan, contact your legal or tax advisor.
3 Network Blue is one of our Preferred Provider Networks made up of independent hospitals, physicians and ancillary providers.
4 CYD = Calendar Year Deductible
5 Coinsurance is the percentage the member pays for service.

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

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Benefits for Covered Services	Amount Member Pays
▶ Prescription Drug Program (BlueScript®) **HSA-compatible health plans come with your choice of either the BlueScript Pharmacy Program (Integrated) OR the BlueRx Discounts® Program.**	
For the greatest savings on your prescriptions, always check to see if the pharmacy is in-network for your BlueOptions plan. Your medication will cost you less if you stay in-network. We have identified certain drugs as a 'specialty drug'. These drugs are listed as a 'specialty drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy.	
Pharmacy Deductible (PD)	In-Network CYD
In-Network Prescription Drug Program Retail and Specialty Pharmacy – Generic, Brand and Non-Preferred Mail Order (90 days) – Generic, Brand and Non-Preferred	 PD (In-Network CYD) PD (In-Network CYD)
Out-of-Network Prescription Drug Program Retail and Specialty Pharmacy – Generic, Brand and Non-Preferred Mail Order (90 days) – Generic, Brand and Non-Preferred	 PD + 50% Coinsurance PD + 50% Coinsurance
If you request a Brand Name Prescription Drug when there is a Generic Prescription Drug available, you will be responsible for: 1) the Deductible and the Copayment or Coinsurance applicable to Brand Name Prescription Drugs; and 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. **Your BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Prescription diaphragms and diabetic equipment and supplies.**	
▶ BlueRx Discounts Program	
Pharmacy Deductible	Not Applicable
Generic/Brand/Preferred	Access to Discounts
Mail Order (90 day Supply) Generic/Brand/Preferred	Access to Discounts
▶ Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 CYD CYD + 40% Coinsurance
Emergency Room Facility Services (ER)[6] (per visit) In-Network Out-of-Network	 CYD CYD
Ambulance Services (Ground travel / air and water travel, per day maximum) In-Network and Out-of-Network	$5,000 In-Network CYD
▶ Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services[7] (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	 CYD CYD CYD + 40% Coinsurance
Independent Clinical Lab[7] (e.g. blood work) In-Network Out-of-Network	 CYD CYD + 40% Coinsurance
Outpatient Hospital Facility Services[6] (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	 CYD 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.

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Benefits for Covered Services	Amount Member Pays
▶ Mental Health/Substance Dependency	
Mental Health (Inpatient PCY[8] / Outpatient PCY)	8 Days / 8 Visits
Inpatient Hospital Facility Services (per admit)	
In-Network (Option 1 / Option 2)	CYD
Out-of-Network Per Admission Deductible (PAD)	$500
Out-of-Network	PAD + CYD + 40% Coinsurance
Outpatient Office Visit	
In-Network Specialist	CYD
Out-of-Network	CYD + 40% Coinsurance
Substance Dependency	
Inpatient Hospital Facility Services (per admit)	
In-Network (Option 1 / Option 2)	CYD
Out-of-Network Per Admission Deductible (PAD)	$500
Out-of-Network	PAD + CYD + 40% Coinsurance
Outpatient Office Visit	
In-Network Specialist	CYD
Out-of-Network	CYD + 40% Coinsurance
▶ Other Provider Services	
Provider Services at Hospital and ER[6]	
In-Network and Out-of-Network	In-Network CYD
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center	
In-Network and Out-of-Network	In-Network CYD
Provider Services at Locations other than Office, Hospital and ER[7]	
In-Network Family Physician	CYD
In-Network Specialist	CYD
Out-of-Network	CYD + 40% Coinsurance
▶ Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits
Locations other than Hospital and Physician's Office	
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)	
In-Network (Option 1 / Option 2)	CYD
Out-of-Network	CYD + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics[6]	
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance
Home Health Care (PCY max)	20 Visits
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance
Skilled Nursing Facility (PCY max)	60 days
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance
Hospice	
In-Network	CYD
Out-of-Network	CYD + 40% Coinsurance

8 PCY = Per Calendar Year

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Benefits for Covered Services	Amount Member Pays	
▶ **Hospital/Surgical**		
Ambulatory Surgical Center Facility (ASC)[7] In-Network Out-of-Network	 CYD CYD + 40% Coinsurance	
Inpatient Hospital Facility and Rehabilitation Services[6] (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation limit PCY - 21 days CYD $500 PAD + CYD + 40% Coinsurance	
Outpatient Hospital Facility Services[7] (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All Other Services (Option 1 / Option 2) Out-of-Network Facility	 CYD CYD CYD + 40% Coinsurance	
Emergency Room Facility Services (ER)[6] (per visit) In-Network Out-of-Network	 CYD CYD	
▶ **Financial Features**	**Health Plan 626 Single**	**Health Plan 627 Family**
Calendar Year Deductible (CYD) (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	 $5,000 / N/A $10,000 / N/A	 $10,000 / $10,000 $20,000 / $20,000
Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	$500	$500
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	0% / 40%	0% / 40%
Out-of-Pocket Maximum (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD; Includes Prescription Drugs if BlueScript Pharmacy Program is purchased. 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.)	 $5,000 / N/A $25,000 / N/A	 $10,000 / $10,000 $25,000 / $25,000
Total Lifetime Maximum Benefit (per member)	No Maximum	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.