

## Understanding Your Share for Covered Services

This health insurance policy<sup>1</sup> is designed to be paired with a Health Savings Account (HSA<sup>2</sup>). 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<sup>3</sup> is the Preferred Provider Network designated as “In-Network” for BlueOptions.

### Benefits for Covered Services

### Amount Member Pays

Office Services	
<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	CYD <sup>4</sup> CYD CYD + 20% Coinsurance <sup>5</sup> CYD CYD + 20% Coinsurance
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET,CT, Nuclear Med.) In-Network Out-of-Network	CYD CYD + 20% Coinsurance
<b>Allergy Injections</b> (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	CYD CYD CYD + 20% Coinsurance
<b>Medical Pharmacy</b> (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Provider (\$200 Monthly Out-of-Pocket Maximum <sup>6</sup> ) Out-of-Network	In-Network CYD CYD + 50% Coinsurance
Preventive Care	
<b>Adult Wellness Benefit Maximum</b> (PCY <sup>7</sup> , includes Well Woman and Routine Adult Physical Exam and Immunizations) In-Network Out-of-Network	No Maximum \$150
<b>Routine Adult Physical Exam and Immunizations</b> (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$0 \$0 20% Coinsurance
<b>Well Woman Exam</b> (e.g. Annual GYN) (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$0 \$0 20% Coinsurance
<b>Mammograms</b> (Covered at 100% of Allowed Amount, In- and Out-of-Network)	\$0
<b>Well Child</b> (No PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	\$0 \$0 20% Coinsurance

1 Policies have limitations and exclusions and are medically underwritten.

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 NetworkBlue 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 will pay for the service.

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

7 PCY = Per Calendar Year

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

# BlueOptions IU65 Plan 622 / 623

## Benefits for Covered Services

## Amount Member Pays

Prescription Drug Program (BlueScript®)	
<b>HSA-compatible health plans come with your choice of either the BlueScript® Pharmacy Program (Integrated) OR the BlueRx Discounts® Program.</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</b>	In-Network CYD
<b>In-Network Prescription Drug Program</b> Retail and Specialty Pharmacy – Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred	In-Network CYD In-Network CYD
<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	In-Network CYD + 50% Coinsurance In-Network CYD + 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 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.	
<b>Your BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Generic Prescription diaphragms and diabetic equipment and supplies.</b>	
BlueRx Discounts Program	
<b>Pharmacy Deductible</b>	Not Applicable
<b>Generic/Brand/Preferred</b>	Access to Discounts
<b>Mail Order (90 day Supply) Generic/Brand/Preferred</b>	Access to Discounts
Emergency Medical Care	
<b>Urgent Care Centers</b> In-Network Out-of-Network	CYD CYD + 20% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>9</sup></b> (per visit) In-Network Out-of-Network	CYD CYD + 20% Coinsurance
<b>Ambulance Services</b> (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network	\$5,000 In-Network CYD
Outpatient Diagnostic Services	
<b>Independent Diagnostic Testing Facility Services<sup>9</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	CYD CYD CYD + 20% Coinsurance
<b>Independent Clinical Lab<sup>9</sup></b> (e.g. blood work) In-Network / Out-of-Network	CYD / CYD + 20% Coinsurance
<b>Outpatient Hospital Facility Services<sup>8</sup></b> (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	CYD / CYD CYD + 20% Coinsurance

8 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.

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

# BlueOptions IU65 Plan 622 / 623

## Benefits for Covered Services

## Amount Member Pays

Mental Health/Substance Dependency	
<b>Mental Health</b> (Inpatient PCY / Outpatient PCY / Lifetime Maximum) 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	\$2,000 / \$600 / \$10,000  CYD / CYD \$500 PAD PAD + CYD + 20% Coinsurance  CYD CYD + 20% Coinsurance
<b>Substance Dependency</b> (Lifetime max) 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	\$2,000  CYD \$500 PAD PAD + CYD + 20% Coinsurance  CYD CYD + 20% Coinsurance
Other Provider Services	
<b>Provider Services at Hospital and ER<sup>8</sup></b> In-Network / Out-of-Network	In-Network CYD
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center</b> In-Network / Out-of-Network	In-Network CYD
<b>Provider Services at Locations other than Office, Hospital and ER<sup>9</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network	CYD CYD CYD + 20% Coinsurance
Other Special Services	
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations</b> (PCY max) In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	\$1,500 CYD CYD + 20% Coinsurance  CYD / CYD CYD + 20% Coinsurance
<b>Durable Medical Equipment, Prosthetics and Orthotics<sup>8</sup></b> In-Network Out-of-Network	CYD CYD + 20% Coinsurance
<b>Home Health Care</b> (PCY max) In-Network Out-of-Network	\$2,500 CYD CYD + 20% Coinsurance
<b>Skilled Nursing Facility</b> (PCY max) In-Network Out-of-Network	60 days CYD CYD + 20% Coinsurance
<b>Hospice</b> (Lifetime max) In-Network Out-of-Network	No Maximum CYD CYD + 20% Coinsurance
Hospital/Surgical	
<b>Ambulatory Surgical Center Facility (ASC)<sup>9</sup></b> In-Network / Out-of-Network	CYD / CYD + 20% Coinsurance
<b>Provider Services Rendered at an ASC<sup>9</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network	CYD CYD CYD + 20% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services<sup>8</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 / CYD \$500 PAD PAD + CYD + 20% Coinsurance

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## Benefits for Covered Services

## Amount Member Pays

<b>Outpatient Hospital Facility Services<sup>9</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	CYD CYD CYD + 20% Coinsurance	
<b>Emergency Room Facility Services (ER)<sup>9</sup></b> (per visit) In-Network Out-of-Network	CYD CYD + 20% Coinsurance	
<b>Financial Features</b>	<b>622 Single</b>	<b>623 Family</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)	\$2,500 / N/A \$5,000 / N/A	\$5,000 / \$5,000 \$10,000 / \$10,000
<b>Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$500	\$500
<b>Coinsurance</b> In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	0% / 20%	0% / 20%
<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.)	\$2,500 / N/A \$10,000 / N/A	\$5,000 / \$5,000 \$20,000 / \$20,000
<b>Total Lifetime Maximum Benefit</b> (per person)	\$5,000,000	

## 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.