

BlueOptions

For Individuals Under 65

Benefit Summary for Health Plan 0511



Understanding Your Share for Covered Services

This health insurance policy¹ 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.

NetworkBlue² is the Preferred Provider Network designated as "In-Network" for BlueOptions.

Benefits for Covered Services

Amount Member Pays

Benefits for Covered Services	Amount Member Pays
► Office Services	
Physician Office Services 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 + 20% Coinsurance ⁴ CYD ³ + 40% Coinsurance \$10 Copayment CYD + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) In-Network Out-of-Network	\$250 Copayment 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).	Available
Allergy Injections (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	\$10 Copayment \$10 Copayment CYD + 40% Coinsurance
Medical Pharmacy – Physician-Administered Medications (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum ⁵ 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. 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 Out-of-Network	\$0 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 NetworkBlue 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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► Prescription Drug Program (BlueScript)[®]	
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)	\$1,500 (Brand Only)
In-Network Prescription Drug Program Retail and Specialty Pharmacy – Generic / Brand / Non-Preferred Mail Order (90 days) – Generic / Brand / Non-Preferred	\$10 Copayment / PD + 40% Coins. / PD + 50% Coins \$25 Copayment / PD + \$125 Copayment / PD + \$200 Copayment
Out-of-Network Prescription Drug Program 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
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, Generic Prescription diaphragms and diabetic equipment and supplies.	
► Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
Emergency Room Facility Services (ER)⁶ (per visit) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance
Ambulance Services (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network	\$5,000 In-Network CYD
► Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services⁷ (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
Independent Clinical Lab⁷ (e.g. blood work) In-Network / Out-of-Network	\$0 Copayment / CYD + 40% Coinsurance
Outpatient Hospital Facility Services⁶ (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	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.

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► Mental Health/Substance Dependency	
Mental Health (Inpatient PCY ⁸ / 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
Substance Dependency 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
► Other Provider Services	
Provider Services at Hospital and ER⁶ In-Network / Out-of-Network	In-Network CYD + 20% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center In-Network / Out-of-Network	In-Network CYD + 20% Coinsurance
Provider Services at Locations other than Office, Hospital and ER⁷ In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
► Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max) 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
Durable Medical Equipment, Prosthetics and Orthotics⁶ In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
Home Health Care (PCY max) In-Network Out-of-Network	20 visits CYD + 20% Coinsurance CYD + 40% Coinsurance
Skilled Nursing Facility (PCY max) In-Network Out-of-Network	60 days CYD + 20% Coinsurance CYD + 40% Coinsurance
Hospice In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
► Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)⁷ In-Network / Out-of-Network	\$200 Copayment / CYD + 40% Coinsurance
Provider Services Rendered at an ASC⁷ In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance

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Inpatient Hospital Facility and Rehabilitation Services⁶ (per admit) 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
Outpatient Hospital Facility Services⁷ (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
Emergency Room Facility Services (ER)⁸ (per visit) In-Network / Out-of-Network	CYD + 20% Coinsurance
► Financial Features	
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)	\$1,500 / NA \$3,500 / \$6,500
Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	\$500
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	20% / 40%
Out-of-Pocket Maximum (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.)	\$5,000 / \$10,000 \$25,000 / \$25,000
Total Lifetime Maximum Benefit (per person)	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.