

BlueChoice

Schedule of Benefits - Plan 0317

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	\$750	\$2,000
Per Family per BP	\$2,250	\$6,000
Per Admission Deductible (PAD)	\$0	\$300
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	\$5,000	Combined with INN
Per Family per BP	\$15,000	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.

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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.

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OFFICE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Office Visits rendered by Primary Care Physicians	\$50 Copay	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	\$50 Copay	Not Covered
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	Not Covered
Outpatient Therapies and Spinal Manipulation rendered by Primary Care Physicians	\$50 Copay	DED + 40%
Specialist Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Telemedicine General Medicine and Urgent Care rendered by a designated Telemedicine Vendor	\$25 Copay	Not Covered
Specialized Care rendered by a designated Telemedicine Vendor	Not Covered	Not Covered

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VIRTUAL HEALTH	YOU PAY
Virtual Visits General Medicine and Urgent Care rendered by a designated Virtual Care Provider	\$50 Copay
Specialized Care rendered by a designated Virtual Care Provider	DED + 20%

Please visit <http://www.floridablue.com/docview/virtualhealth> for more information on Virtual Visits.

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.

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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	\$0 Copay
Mammograms	\$0 Copay	\$0 Copay

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OUTPATIENT DIAGNOSTIC SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Independent Clinical Lab	20%	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	\$0 Copay	\$0 Copay
Convenient Care Centers	\$20 Copay	DED + 40%
Emergency Room Visits Facility	DED + 20%	DED + 20%
Physician Services	DED + 20%	DED + 20%
Urgent Care Center	\$60 Copay	DED + \$60 Copay

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%

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HOSPITAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient		
Facility Services (per admission)	DED + 20%	*PAD + 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.

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MENTAL HEALTH SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	\$0 Copay	40%
Outpatient Facility Services rendered at Emergency Room	\$0 Copay	\$0 Copay
Hospital, Psychiatric or Substance Abuse Facility	\$0 Copay	40%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	\$0 Copay	40%
Specialist Office	\$0 Copay	40%
Emergency Room	\$0 Copay	\$0 Copay
Hospital, Psychiatric or Substance Abuse Facility	\$0 Copay	\$0 Copay
Primary Care Physician at all other locations	\$0 Copay	40%
Specialist at all other locations	\$0 Copay	40%

SUBSTANCE DEPENDENCY SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	\$0 Copay	40%
Outpatient Facility Services rendered at Emergency Room	\$0 Copay	\$0 Copay
Hospital, Psychiatric or Substance Abuse Facility	\$0 Copay	40%
Physician and other health care professionals licensed to perform such Services rendered at Primary Care Physician Office	\$0 Copay	40%
Specialist Office	\$0 Copay	40%
Emergency Room	\$0 Copay	\$0 Copay
Hospital, Psychiatric or Substance Abuse Facility	\$0 Copay	\$0 Copay
Primary Care Physician at all other locations	\$0 Copay	40%
Specialist at all other locations	\$0 Copay	40%

OTHER SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Birth Center	DED + 20%	DED + 40%
Diabetic Equipment	\$0 Copay	DED + 40%
Dialysis Center	DED + 20%	DED + 40%
Durable Medical Equipment	DED + 20%	DED + 40%
Enteral Formula	DED + 20%	DED + 40%
Home Health Services	DED + 20%	DED + 40%
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	DED + 20%	DED + 40%

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Home Health Care visits.....20

Orthotic Shoes and Other Supportive Devices for the Feet.....4

Outpatient Therapies and Spinal Manipulation visits (combined)35

Note: Spinal Manipulations are limited to 26 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

Skilled Nursing Facility days60

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.

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