BlueOptions

For Individuals Under 65

Benefit Summary for Health Plan 700

FLORIDA
An Independent Licensee of the Blue Cross and Blue Shield Association

Understanding Your Share for Covered Services

This health insurance policy[1] provides you with routine health care services, such as physician office services, as well as basic protection against major illnesses requiring hospitalization or surgery. We encourage you to carefully review what the plan covers and understand what your out-of-pocket costs may be.

NetworkBlue[2] is the Preferred Provider Network designated as "In-Network" for BlueOptions.

Benefits for Covered Services	Amount Member Pays
▶ Office Services	
Physician Office Services (Includes e-office visits, allergy injections, in-office surgery, and Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network Family Physician	Balance[3] up to Allowed Amount[4] after BCBSF pays up to $50
In-Network Specialist	Balance up to Allowed Amount after BCBSF pays up to $75
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
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
▶ Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Mammograms	
In-Network	$0
Out-of-Network	CYD[5] + 50% Coinsurance[6]
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network	$0
Out-of-Network	CYD + 50% Coinsurance
▶ Prescription Drug Program (BlueScript®)	
For the greatest savings on your prescriptions, always check to see if the pharmacy is in-network for your BlueScript 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.	

1 Policies have limitations and exclusions and are medically underwritten.
2 Network Blue is one of our Preferred Provider Networks made up of independent hospitals, physicians and ancillary providers.
3 "Balance" is the difference between our payment and the amount an In-Network provider agrees to accept as payment in full for covered services (the allowed amount). For Out-of-Network providers, "balance" is the difference between our payment (allowed amount) and the provider's charge. You are responsible for paying the doctor or provider this "balance".
4 The Allowed Amount is the amount we have negotiated with providers for payment of covered services, instead of a member paying the full charge for a service.
5 CYD = Calendar Year Deductible —The amount, if any, per calendar year, you owe before we begin to pay for covered services.
6 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) (Continued)	
Pharmacy Deductible (PD)	$800 (Brand and Non-Preferred Only)
In-Network Prescription Drug Program	
Retail and Specialty Pharmacy – Generic / Brand / Non-Preferred	$10 Copay / PD + $60 Copay / PD + $100 Copay
Mail Order (90 days) – Generic / Brand / Non-Preferred	$25 Copay / PD + $150 Copay /PD + $250 Copay
Out-of-Network Prescription Drug Program	
Retail and Specialty Pharmacy–Generic / Brand and Non-Preferred	50% Coinsurance / PD + 50% Coinsurance
Mail Order (90 days) – Generic / Brand and Non-Preferred	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.**	
▶ Emergency Medical Care	
Urgent Care Centers	
In-Network	Balance up to Allowed Amount after BCBSF pays up to $50
Out-of-Network	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Emergency Room Facility Services (ER) (per visit)	
If Admitted or if a surgical service is performed	
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
Non-Surgical Services	
Per Visit Deductible (PVD)	$500
In-Network and Out-of-Network	PVD + In-Network CYD + 10% Coinsurance
Ambulance Services (Ground / air and water travel, per day maximum)	$5,000
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
▶ Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (Except AIS)	$75 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copayment
Out-of-Network	CYD + 50% Coinsurance
Independent Clinical Lab (e.g. blood work)	
In-Network	$0
Out-of-Network	CYD + 50% Coinsurance
Outpatient Hospital Facility Services[7] (per visit) (Services Related to Surgery Only) (e.g. proximately related Blood Work and X-rays)	
In-Network (Option 1 / Option 2)	CYD + 10% Coinsurance
Out-of-Network	CYD + 50% Coinsurance

7 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.

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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 + 10% Coinsurance
Out-of-Network Per Admission Deductible (PAD)	$500
Out-of-Network	PAD + CYD + 50% Coinsurance
Outpatient Office Visit	
In-Network Specialist	Balance up to Allowed Amount after BCBSF pays up to $75
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Substance Dependency	
Inpatient Hospital Facility Services (per admit)	
In-Network (Option 1 / Option 2)	CYD + 10% Coinsurance
Out-of-Network Per Admission Deductible (PAD)	$500
Out-of-Network	PAD + CYD + 50% Coinsurance
Outpatient Office Visit	
In-Network Specialist	Balance up to Allowed Amount after BCBSF pays up to $75
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
▶ Other Provider Services	
Provider Services at Hospital and ER	
If Admitted or if a surgical service is performed	
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
Non-Surgical ER Services	
Per Visit Deductible (PVD)	$500
In-Network and Out-of-Network	PVD + In-Network CYD + 10% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	Balance up to Allowed Amount after BCBSF pays up to $50
In-Network Specialist	Balance up to Allowed Amount after BCBSF pays up to $75
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
▶ 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 + 10% Coinsurance
Out-of-Network	CYD + 50% Coinsurance
Outpatient Hospital Facility	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics (If proximately related to surgery, Inpatient Admissions or ER services only)	
In-Network	CYD + 10% Coinsurance
Out-of-Network	CYD + 50% Coinsurance

8 PCY = Per Calendar Year

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▶ Other Special Services (Continued)	
Home Health Care (PCY max) In-Network Out-of-Network	45 Visits CYD + 10% Coinsurance CYD + 50% Coinsurance
Skilled Nursing Facility (PCY max) In-Network Out-of-Network	45 Days CYD + 10% Coinsurance CYD + 50% Coinsurance
Hospice In-Network Out-of-Network	 CYD + 10% Coinsurance CYD + 50% Coinsurance
▶ Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) (Services Related to Surgery Only) In-Network Out-of-Network	 CYD + 10% Coinsurance CYD + 50% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PCY max) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation Services limit - 21 days PCY CYD + 10% Coinsurance $500 PAD + CYD + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) (Services Related to Surgery Only) In-Network (Option 1 / Option 2) Out-of-Network	 CYD + 10% Coinsurance CYD + 50% Coinsurance
Emergency Room Facility Services (ER) (per visit) If Admitted or if a surgical service is performed In-Network and Out-of-Network Non-Surgical Services Per Visit Deductible (PVD) In-Network and Out-of-Network	 In-Network CYD + 10% Coinsurance $500 PVD + In-Network CYD + 10% Coinsurance
▶ Dental Coverage	
Preventive and Basic Dental Services Includes coverage for services such as routine oral exams and cleanings 2 times/yr, bitewing x-rays once/yr, and fluoride for children 2 times/yr, fillings and denture repairs. In-Network Out-of-Network	 Balance up to Allowed Amount after BCBSF pays up to $50 Balance up to the provider's charge after BCBSF pays up to $50
▶ Financial Features	
Calendar Year Deductible (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	 $250 / N/A $750 / N/A
Per Admission Deductible (PAD) (Out-of-Network Inpatient Hospital Facility Services)	 $500
Emergency Room Non-Surgical Per Visit Deductible (PVD) (Facility and Physician Services) In-Network and Out-of-Network	 $500

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▶ **Financial Features (Continued)**	
Coinsurance (Member pays) In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 10% of the Allowed Amount 50% of the Allowed Amount (+ the balance of provider's charge for non-par providers)
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, Emergency Room PVD, and the balance after BCBSF maximum payment of $50 or $75. 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 $5,000 / N/A
Total Lifetime Maximum Benefit (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 Hospital Surgical Plus Contract. For a complete description of benefits and exclusions, please see 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 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 Hospital Surgical Plus 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.

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