

# BlueOptions

## Schedule of Benefits – Plan 03769

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at [www.floridablue.com](http://www.floridablue.com). If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

**Your Benefit Period..... 01/01 – 12/31**

### Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
<b>Deductible (DED)</b>		
Per Person per Benefit Period	\$300	\$600
Per Family per Benefit Period	\$600	\$1,200
<b>Per Admission Deductible (PAD)</b>	Not Applicable	Not Applicable
<b>Coinsurance</b> (The percentage of the Allowed Amount <b>you pay</b> for Covered Services)	20%	25%
<b>Out-of-Pocket Maximums</b>		
Per Person per Benefit Period	\$5,000	\$6,500
Per Family per Benefit Period	\$13,200	\$20,000

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.

What **applies** to out-of-pocket maximums?

- DED
- Coinsurance
- Copayments
- Any Prescription Drug Cost Share amounts

What **does not apply** to out-of-pocket maximums?

- Non-covered charges
- Any benefit penalty reductions
- Charges in excess of the Allowed Amount

### **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 Copayment is listed in the charts that follow, the Copayment applies per visit.

## Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
<b>Office visits</b> and Services not otherwise outlined in this table rendered by Family Physicians	\$30	DED + 25%
Other health care professionals licensed to perform such Services	\$50	DED + 25%
<b>Advanced Imaging Services</b> (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) and <b>Diagnostic testing</b> (e.g. Lab, x-ray) rendered by Family Physicians	\$30	DED + 25%
Other health care professionals licensed to perform such Services	\$50	DED + 25%
<b>Allergy Injections</b> rendered by Family Physicians	\$5	DED + 25%
Other health care professionals licensed to perform such Services	\$5	DED + 25%
<b>E-Visits</b> rendered by Family Physicians	\$30	DED + 25%
Other health care professionals licensed to perform such Services	\$50	DED + 25%
<b>Durable Medical Equipment, Prosthetics, and Orthotics</b>	DED + 20%	DED + 25%
<b>Convenient Care Centers</b>	\$30	DED + 25%

## Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	\$30	DED + 25%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	\$50	DED + 25%
Out-of-Pocket Maximum per Person per Month	\$200	Not Applicable
<p><b>Important</b> – 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 as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.</p>		

## Preventive Health Services

Benefit Description	In-Network	Out-of-Network
<b>Adult Wellness Services</b> Rendered by Family Physicians	\$0	25%
Other health care professionals licensed to perform such Services	\$0	25%
All other locations	\$0	25%
<b>Adult Well Woman Services</b> Rendered by Family Physicians	\$0	25%
Other health care professionals licensed to perform such Services	\$0	25%
All other locations	\$0	25%
<b>Child Health Supervision Services</b> rendered by Family Physicians	\$0	25%
Other health care professionals licensed to perform such Services	\$0	25%
All other locations	\$0	25%
<b>Mammograms</b>	\$0	\$0
<b>Routine Colonoscopy</b>	\$0	\$0

## Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
<b>Independent Clinical Lab</b>	\$30	DED + 25%
<b>Independent Diagnostic Testing Facility</b> Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	\$30	DED + 25%
All other diagnostic Services (e.g., X-rays)	\$30	DED + 25%
<b>Outpatient Hospital Facility</b>	DED + 20%	DED + 25%

## Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulance Services</b>	DED + 20%	In-Network DED + 20% of Billed Amount
<b>Emergency Room Visits</b>	See <b>Hospital Services</b> <b>Emergency Room Visits</b>	
<b>Urgent Care Center</b>	\$30	DED + \$30

## Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulatory Surgical Center</b>		
Facility	DED + 20%	DED + 25%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	DED + 25%
Rendered by		
Family Physicians	DED + 20%	DED + 25%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 25%
<b>Outpatient Hospital Facility</b>	See <b>Hospital Services</b> <b>Outpatient</b>	

## Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
<b>Inpatient</b>			
Facility Services	DED + 20%	DED + 20%	**DED + 25%
Physician and other health care professional Services	DED + 20%		DED + 25%
<b>Outpatient</b>			
Facility (per visit)	DED + 20%	DED + 20%	DED + 25%
Physician and other health care professional Services	DED + 20%		DED + 25%
Therapy Services	DED + 20%	DED + 20%	DED + 25%
<b>Emergency Room Visits</b>			
Facility	\$100 + DED + 20%		\$100 + In-Network DED + 20%
Physician and other health care professional Services	DED + 20%		DED + 20%

\*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

\*\*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 Emergency Room Copayment will apply to that admission.

### **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. If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not participating in our Traditional Program, you will be responsible for the difference between what we pay and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

## Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
<b>Mental Health Services</b>		
Outpatient		
Facility Services rendered at:		
Emergency Room	\$100 + DED + 20%	\$100 + In-Network DED + 20%
Hospital	DED + 20%	DED + 25%
Physician Services at Hospital	DED + 20%	DED + 25%
Physician Services at ER	DED + 20%	DED + 20%
Physician and other health care professionals licensed to perform such Services		
Family Physician office	\$30	DED + 50%
Specialist office	\$50	DED + 50%
All other locations	DED + 20%	DED + 25%
Inpatient		
Facility Services	DED + 20%	DED + 25%
Physician and other health care professionals licensed to perform such Services	DED + 20%	DED + 25%

Benefit Description	In-Network	Out-of-Network
<p><b>Substance Dependency Care and Treatment Services</b></p> <p>Outpatient</p> <p>Facility Services rendered at:</p> <p>Emergency Room</p>	\$100 + DED + 20%	\$100 + In-Network DED + 20%
Hospital	DED + 20%	DED + 25%
Physician Services at Hospital	DED + 20%	DED + 25%
Physician Services at ER	DED + 20%	DED + 20%
<p>Physician and other health care professionals licensed to perform such Services</p> <p>Family Physician office</p> <p>Specialist office</p> <p>All other locations</p>	DED + 20%	DED + 50%
<p>Inpatient</p> <p>Facility Services</p>	DED + 20%	DED + 25%
Physician and other health care professionals licensed to perform such Services	DED + 20%	DED + 25%

## Other Services

Benefit Description	PPO	Providers Not Participating in PPO
<b>Acupuncture</b>	DED + 20%	DED + 25%
<b>Chiropractor</b>	DED + 20%	DED + 25%
<b>Outpatient Therapy rendered at a free standing Facility</b>	DED + 20%	DED + 25%
<b>Skilled Nursing Facility</b>	DED + 20%	DED + 25%
<b>Home Health Care</b> <b>Note:</b> same cost share applies to drugs administered in the home	DED + 20%	DED + 25%
<b>Hospice</b>	DED + 20%	DED + 25%
<b>Birthing Center</b>	DED + 20%	DED + 25%
<b>Dialysis</b>	DED + 20%	DED + 25%

## Benefit Maximums

**Accident Care** ..... \$400

Covered Services in connection with an Accident are not subject to any Deductible or Copayment requirements. Coinsurance will be reimbursed at 100% of the Allowed Amount up to the benefit maximum per Accident within a 90-day period.

**Note:** Once the benefit maximum has been reached, all other Insured's financial responsibilities will apply including DED and Coinsurance.

**Home Health Care** Visits per Benefit Period..... 20

**Mental Health** and Substance Dependency Care and Treatment **Services** (Inpatient) - visits/days or combination of inpatient and Partial Hospitalization days per Covered Plan Participant per BP ..... 30

**Mental Health** and Substance Dependency Care and Treatment **Services** (Outpatient) - Office visits/days per Covered Plan Participant per BP ..... 50

**Outpatient Therapies** (Cardiac, Occupational, Physical, Speech, Respiratory & Massage Therapy)Visits per Benefit Period ..... 75

**Note:** Refer to the Benefit Booklet for reimbursement guidelines.

**Skilled Nursing Facility and Inpatient Rehabilitation** days per Benefit Period (combined) ..... 90

**Spinal Manipulation** visits per Benefit Period ..... 26

## **Additional Benefits/Features**

### **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 BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

### **Prescription Drug Program**

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.

### **Admission Certification Requirements**

All Hospital admissions in the state of Florida must be certified. The following penalties will apply for admissions within the state of Florida which are not certified.

1. Admissions to a Hospital that is a PPC Provider - No penalty for the Covered Plan Participant. It is the responsibility of the PPC Hospital/Physician to obtain admission certification.
2. Hospitals that are not BCBSF Providers - any non-certified admissions in the state of Florida are subject to a 25% benefit penalty reduction. The Covered Plan Participant is responsible for obtaining certification for the admission from BCBSF and for any applicable benefit reductions for failure to obtain such certification.