BlueOptions

Schedule of Benefits – Plan 03768

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. 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
Deductible (DED) Per Person per Benefit Period	$500	
Per Family per Benefit Period	$1000	
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	25%	40%
Out-of-Pocket Maximums Per Person per Benefit Period	$6,350	
Per Family per Benefit Period	$12,700	

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 • PAD, when applicable • Coinsurance • Copayments
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
Office visits and Services not otherwise outlined in this table rendered by Family Physicians	$30	$40
Other health care professionals licensed to perform such Services	$30	$40
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	$200	$200
Other health care professionals licensed to perform such Services	$200	$200
All other diagnostic Services (e.g., X-rays)	$50	DED + 40%
Allergy Injections rendered by Family Physicians	$10	$10
Other health care professionals licensed to perform such Services	$10	$10
E-Visits rendered by Family Physicians	$10	DED + 40%
Other health care professionals licensed to perform such Services	$10	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 25%	DED + 40%
Convenient Care Centers	$20	DED + 40%

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Rendered by Family Physicians	$0	$40
Other health care professionals licensed to perform such Services	$0	$40
All other locations	$0	DED + 40%
Adult Well Woman Services Rendered by Family Physicians	$0	$40
Other health care professionals licensed to perform such Services	$0	$40
All other locations	$0	DED + 40%
Child Health Supervision Services rendered by Family Physicians	$0	$40
Other health care professionals licensed to perform such Services	$0	$40
All other locations	$0	DED + 40%
Physician Services at Hospital and ER	$0	$50
Independent Clinical Lab (Adult/Child)	$0	DED + 40%
Independent Diagnostic Testing Facility (Adult/Child) Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$0	$200
All other diagnostic Services (e.g., X-rays)	$0	DED + 40%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$200	$200
All other diagnostic Services (e.g., X-rays)	$50	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	DED + 25%	In-Network DED + 25% of the billed amount
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	$50	DED + 40%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	$200	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	$45	$45
Other health care professional Services rendered by all other Providers	$30	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* PPO Participating and Out-of-State BlueCard® Participating PPO Providers	
Inpatient			
Facility Services (per admission)	DED + 25%		DED + 40%
Physician and other health care professional Services	$50		$50
Outpatient			
Facility (per visit)	DED + 25%		DED + 40%
Physician and other health care professional Services	$50		$50
Therapy Services	$45	$60	DED + 40%
Emergency Room Visits			
Facility (Copayment waived if admitted)	$100		$100
Physician and other health care professional Services	$50		$50

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

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Care and Treatment Services Outpatient Facility Services rendered at: Emergency Room	$100	$100
Hospital	DED + 25%	DED + 40%
Physician Services at Hospital and ER	$30	$40
Physician and other health care professionals licensed to perform such Services Family Physician office	$30	$40
Specialist office	$30	$40
All other locations	$30	$40
Inpatient Facility Services	DED + 25%	DED + 40%
Physician and other health care professionals licensed to perform such Services	$30	$40

Benefit Maximums

Acupuncture Visits per Benefit Period 28

Home Health Care Visits per Benefit Period..... 30

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Cardiac, Occupational, Physical, Speech Therapies (Combined) Therapies Visits per Benefit Period..... 122

Note: Therapy Services related to Autism will apply to the Outpatient Therapy maximum, but coverage is extended beyond the therapy maximum for therapy services with an Autism diagnosis. Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility days per Benefit Period..... 60

Spinal Manipulations and Massage Therapy Visits Per Person Per BP 26

Note: Spinal Manipulations are limited to 26 visits per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulations benefit maximum. Refer to the Benefit Booklet for reimbursement guidelines.

Surgical Procedures for Treatment of Morbid Obesity $25,000

Additional Benefits/Features

Deductible Carry-over

Any amounts credited by BCBSF towards your individual DED for claims for Covered Services incurred during the last three months of the prior Benefit Period will be carried over to reduce your Individual DED requirement for the current Benefit Period.

In-Network Providers

NetworkBlue is the panel of NetworkBlue Providers designated as In-Network for your plan. Refer to your BlueOptions Provider directory for a complete listing of your In-Network Providers. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers or PPO Providers, payment will be made based on In-Network benefits.

Note: Please note that 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. We will pay for Covered Services rendered by any Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. If such Covered Services were rendered by a Physician who is not In-Network, you will be responsible for the difference between what we pay and the Physician's charge if the Physician is not participating in our Traditional Program. Claims paid in accordance with this Note will be applied to the In-Network Deductibles and In-Network Out-of-Pocket Maximums.