

# BlueOptions

## Schedule of Benefits – Plan 05360

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<sup>®</sup> 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		\$1,500
Per Family per Benefit Period		\$3,000
<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)	25%	40%
<b>Out-of-Pocket Maximums</b>		
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
<b>Office visits</b> rendered by		
Family Physicians	\$50	\$60
Other health care professionals licensed to perform such Services	DED + 25%	DED + 40%
<b>Advanced Imaging Services</b> (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	DED + 25%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 25%	DED + 40%
<b>Allergy Injections</b> rendered by		
Family Physicians	\$10	\$10
Other health care professionals licensed to perform such Services	\$10	\$10
<b>E-Visits</b> rendered by		
Family Physicians	\$10	DED + 40%
Other health care professionals licensed to perform such Services	\$10	DED + 40%
<b>Therapy Services</b> rendered by		
Family Physicians	DED + 25%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 25%	DED + 40%
<b>Durable Medical Equipment, Prosthetics, and Orthotics</b>	DED + 25%	DED + 40%
<b>Convenient Care Centers</b>	DED + 25%	DED + 40%

## Preventive Health Services

Benefit Description	In-Network	Out-of-Network
<b>Adult Wellness Services</b>		
Rendered by		
Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
<b>Adult Well Woman Services</b>		
Rendered by		
Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
<b>Child Health Supervision Services</b> rendered by		
Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
<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>	DED + 25%	DED + 40%
<b>Independent Diagnostic Testing Facility</b>  Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 25%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 25%	DED + 40%
<b>Outpatient Hospital Facility</b>	See <b>Hospital Services Outpatient</b>	

## Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulance Services</b>	DED + 25%	
<b>Emergency Room Visits</b>	See <b>Hospital Services Emergency Room Visits</b>	
<b>Urgent Care Center</b>	DED + 25%	DED + 40%

## Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulatory Surgical Center</b>  Facility (per visit)	DED + 25%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 25%	DED + 40%
Other health care professional Services rendered by all other Providers	DED + 25%	DED + 40%
<b>Outpatient Hospital Facility</b>	See <b>Hospital Services 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 (per admission)	DED + 25%	DED + 25%	DED + 40%
Physician and other health care professional Services	DED + 25%		DED + 40%
<b>Outpatient</b>			
Facility (per visit)	DED + 25%	DED + 25%	DED + 40%
Physician and other health care professional Services	DED + 25%		DED + 40%
Therapy Services	DED + 25%	DED + 25%	DED + 40%
<b>Emergency Room Visits</b>			
Facility	DED + 25%		In-Network DED + 25%
Physician and other health care professional Services	DED + 25%		In-Network DED + 25%

\*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
<b>Mental Health and Substance Dependency Treatment Services</b> Outpatient Facility Services rendered at:		
Emergency Room	DED + 25%	In-Network DED + 25%
Hospital	DED + 25%	DED + 40%
Physician Services at ER	DED + 25%	In-Network DED + 25%
Physician Services at Hospital	DED + 25%	DED + 40%
Physician and other health care professionals licensed to perform such Services rendered at:		
Family Physician office	\$50	\$60
Specialist office	DED + 25%	DED + 40%
All other locations	DED + 25%	DED + 40%
Inpatient		
Facility Services	DED + 25%	DED + 40%
Physician Services at ER	DED + 25%	In-Network DED + 25%
Physician Services at Hospital	DED + 25%	DED + 40%

## Benefit Maximums

<b>Acupuncture</b> Visits per Benefit Period .....	28
<b>Home Health Care</b> Visits per Benefit Period.....	30
<b>Inpatient Rehabilitation</b> days per Benefit Period.....	30
<b>Outpatient Cardiac, Occupational, Physical, Speech Therapies (Combined)</b> Visits per Benefit Period.....	122
<b>Note:</b> 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.	
<b>Skilled Nursing Facility</b> days per Benefit Period .....	60
<b>Spinal Manipulations and Massage Therapy</b> Visits Per Person Per BP .....	26
<b>Note:</b> 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.	
<b>Surgical Procedures for Treatment of Morbid Obesity</b> .....	\$25,000

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## 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.