BlueOptions

Schedule of Benefits – Plan 03559

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	$300	$600
Per Family per Benefit Period	$500	$1,200
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$2,000	$4,000
Per Family per Benefit Period	$6,000	$12,000

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 • PAD, when applicable • 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
Office visits and Services not otherwise outlined in this table rendered by		
Family Physicians	$25	DED + 50%
Other health care professionals licensed to perform such Services	$25	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$25	DED + 50%
Other health care professionals licensed to perform such Services	$25	DED + 50%
Allergy Injections rendered by		
Family Physicians	$5	DED + 50%
Other health care professionals licensed to perform such Services	$5	DED + 50%
E-Visits rendered by		
Family Physicians	$25	DED + 50%
Other health care professionals licensed to perform such Services	$25	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 50%
Convenient Care Centers	$25	DED + 50%
Oral Surgeon (surgical removal of impacted teeth only)	DED + 20%	DED + 20%

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services Rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 20%	DED + 50%
All other diagnostic Services (e.g., X-rays)	DED + 20%	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 20%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	$25	DED + $25

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED + 20%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	In-Network DED + 20%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED + 20%	DED + 20%	**DED + 50%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Outpatient			
Facility (per visit)	DED + 20%	DED + 20%	DED + 50%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Therapy Services	DED + 20%	DED + 20%	DED + 50%
Emergency Room Visits			
Facility (Copayment waived if admitted)	$250 + DED + 20%		$250 + In-Network DED + 20%
Physician and other health care professional Services	DED + 20%		In-Network 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 In-Network Coinsurance 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. This Plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. 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
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room (Copayment waived if admitted)	$250 + DED + 20%	In-Network DED + 20%
Hospital	DED + 20%	DED + 50%
Physician Services at Hospital and ER	DED + 20%	In-Nework DED + 20%
Physician and other health care professionals licensed to perform such Services Family Physician office	$25	DED + 50%
Specialist office	$25	DED + 50%
All other locations	DED + 20%	DED + 50%
Inpatient Facility Services	DED + 20%	DED + 50%
Physician and other health care professionals licensed to perform such Services	DED + 20%	In-Nework DED + 20%

Other Services

Benefit Description	In-Network	Out-of-Network
Birthing Centers	DED + 20%	DED + 50%
Outpatient Rehabilitation Facility	$25	DED + 50%

Benefit Maximums

Acupuncture Services Per Covered Plan Participant Per BP $1,000

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

Outpatient Private Duty Nursing Visits Per Covered Plan Participant per BP 40

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

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.