BlueOptions

Schedule of Benefits

Plan 3769

You should carefully review this Schedule of Benefits, which is part of your Benefit Booklet, to be aware of important information concerning your share of the expenses for Covered Services you receive. Your share of the expenses, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **will vary** depending upon the Provider you choose and the setting in which the Services are rendered. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP". 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 (BP) ..... 01/01 - 12/31

Deductible and Coinsurance Amounts

Benefit Description	In-Network	Out-of-Network
Individual Deductible (DED) per BP	$500	$1,500
Family Deductible (DED) per BP	$1,500	$4,500
Amount Payable by BCBSF	80% of the Allowed Amount	50% of the Allowed Amount
Individual Out-of-Pocket Maximum per BP	$3,000	$6,000
Family Out-of-Pocket Maximum per BP	$6,000	$12,000

Note: Out-of-Pocket Maximums include the DED amount, any applicable Copayments and Coinsurance amounts. Any non-covered charges or charges in excess of the Allowed Amount are not included. Prescription Drug Copayments, DED and/or Coinsurance amounts are not included.

Note: The In-Network DEDs and Out-of-Pocket Maximums and Out-of-Network DEDs and Out-of-Pocket Maximums are separate, and as such, accumulate separately. Therefore, amounts incurred for In-Network shall be applied only to the In-Network DEDs and Out-of-Pocket Maximums and Out-of-Network amounts incurred shall be applied only to Out-of-Network DEDs and Out-of-Pocket Maximums.

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Office Services

Benefit Description	In-Network	Out-of-Network
Physician and other health care professional Services received in the office or any other location except an Ambulatory Surgical Center, Hospital or Hospital Emergency Room:		
Family Physicians 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	$25 Copayment per visit*	50% of the Allowed Amount after DED
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	$60 Copayment per visit*	50% of the Allowed Amount after DED
Allergy Injections rendered by:		
1. Family Physicians	$10 Copayment per visit*	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	$10 Copayment per visit*	50% of the Allowed Amount after DED

Benefit Description	In-Network	Out-of-Network
Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology rendered by:		
1. Family Physicians	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services.	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
E-Visits		
1. Family Physicians	$10 Copayment per visit*	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	$10 Copayment per visit*	50% of the Allowed Amount after DED
Durable Medical Equipment, Prosthetics, and Orthotics	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

Note: You should verify a Provider's participation status whenever possible 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 BlueOptions Provider directory at our web-site at ww.bcbsfl.com.

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Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by:		
1. Family Physicians	80% of the Allowed Amount	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	80% of the Allowed Amount	50% of the Allowed Amount after DED
Out-of-Pocket Maximum per Person per Month (applies only after DED is satisfied.)	$200	Not Applicable

Important – 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.

Outpatient Facility Services

(Locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or Physician's Office)

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Services	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Physician and other health care professional Services rendered at an Ambulatory Surgical Center by:		
1. Radiologists, Anesthesiologists, and Pathologists	$60 Copayment per visit*	$60 Copayment per visit*
2. All other Providers	$60 Copayment per visit*	50% of the Allowed Amount after DED
Independent Diagnostic Testing Facility Services		
1. Advanced Imaging Services: CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
2. All other diagnostic Services	$50 Copayment per visit*	50% of the Allowed Amount after DED
Urgent Care Center	$65 Copayment per visit*	$65 Copayment per visit after DED
Independent Clinical Lab Services	100% of the Allowed Amount	50% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

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Inpatient/Outpatient Services

(Rendered at a Hospital Facility)

Benefit Description	In-Network		Out-of-Network
	Option 1	Option 2 and Out of State BlueCard® Participating	
Inpatient Facility Services	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Outpatient Facility Services 1. Therapy Services	$45 Copayment*	$60 Copayment*	50% of the Allowed Amount after DED
2. All other Services (Applies per visit)	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Inpatient/outpatient Physician and other health care professional Services	$100 Copayment*		$100 Copayment*
Emergency Room Facility Services (Applies per visit) Copayment waived if admitted	$300 Copayment*		$300 Copayment

*These Services are subject to the Copayment only.

Note: Please refer to your Provider Directory to determine the applicable option for each In-Network Hospital.

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Preventive Adult Wellness Services rendered by:		
1. Family Physicians	$25 Copayment per visit*	50% of the Allowed Amount
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	$60 Copayment per visit*	50% of the Allowed Amount
Preventive Adult Well Woman Services rendered by:		
1. Family Physicians	$25 Copayment per visit*	50% of the Allowed Amount
2. Physicians other than Family Physicians and Other health care professionals licensed to perform such Services	$60 Copayment per visit*	50% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
Preventive Child Health Supervision Services rendered by: 1. Family Physicians	$25 Copayment per visit*	50% of the Allowed Amount
2. Physicians other than Family Physicians and Other health care professionals licensed to perform such Services	$60 Copayment per visit*	50% of the Allowed Amount
Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Routine Colonoscopies	100% of the Allowed Amount	100% of the Allowed Amount

*These Services are subject to the Copayment only.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health Services Outpatient Facility Services rendered at:		
1. Emergency Room	$0 Copayment*	100% of the Allowed Amount
2. Hospital	$0 Copayment*	50% of the Allowed Amount
Physician and other health care Professionals licensed to perform such Services rendered at:		
1. Family Physician office	$0 Copayment*	50% of the Allowed Amount
2. Specialist office	$0 Copayment*	50% of the Allowed Amount
3. All other locations	$0 Copayment*	50% of the Allowed Amount

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Benefit Description	In-Network	Out-of-Network
Inpatient 1. Facility Services	$0 Copayment*	50% of the Allowed Amount
2. Physicians and other health care professionals licensed to perform such Services	$0 Copayment*	100% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
Substance Dependency Care and Treatment Services Outpatient Facility Services rendered at:		
1. Emergency Room	$0 Copayment*	100% of the Allowed Amount
2. Hospital	$0 Copayment*	50% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
Physician and other health care professionals licensed to perform such Services rendered at:		
1. Family Physician office	$0 Copayment*	50% of the Allowed Amount
2. Specialist office	$0 Copayment*	50% of the Allowed Amount
3. All other locations	$0 Copayment*	50% of the Allowed Amount
Inpatient 1. Facility Services	$0 Copayment*	50% of the Allowed Amount
2. Physicians and other health care professionals licensed to perform such Services	$0 Copayment*	100% of the Allowed Amount

*These Services are subject to the Copayment only.

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Benefit Maximums

Home Health Care Visits Per Person Per BP 20

Hospice (Combined Inpatient, Outpatient and Home)
Visits/Days Per Person Per BP ..... Unlimited

Inpatient Rehabilitation Days per Person per BP 30

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Visits (Combined) Per Person per BP 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Preventive Adult Wellness Services include:

For purposes of this benefit an adult is 17 years or older.

1. annual physical and/or gynecological exam, including family planning/contraceptive Services; and
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA),

   x-rays, laboratory Services, and immunizations. Routine vision and hearing examinations and screenings are not covered.

Note: The wellness Services above are not subject to the DED. Your share of the expenses may vary based on the location of service and whether the Provider is In-Network or Out-of-Network.

Skilled Nursing Facility Days per Person per BP 60

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 HOI to the Group, amounts applied to your Benefit Period maximums and lifetime maximums under the prior BCBSF or HOI policy, will be applied toward your Benefit Period maximums and lifetime maximums under the Benefit Booklet.

Prescription Drug Program

The Group purchased optional pharmacy coverage from BCBSF. Please refer to the pharmacy program Endorsement issued to the Group.

In-Network Providers

NetworkBlue [name of panel] is the panel of NetworkBlue Providers designated as In-Network for your plan. You may contact the local BCBSF office or access the BlueOptions Provider directory on our web-site at www.bcbsfl.com for a complete listing of your In-Network Providers. If you receive Covered Services outside the state of Florida from BlueCard® participating 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. Claims paid in accordance with this note will be applied to the In-Network DEDs and In-Network Out-of-Pocket Maximums.

Convenient Care Center (In-Network) ..... $25 Copayment per visit.

Convenient Care Center (Out-of-Network) ..... 50% of the Allowed Amount after DED

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BlueScript® Pharmacy Program

Schedule of Benefits

You should carefully review this Pharmacy Program Schedule of Benefits. If you did not receive, or cannot find, the BlueScript Pharmacy Program Endorsement, which this Pharmacy Program Schedule of Benefits is a part of, contact us to obtain one. To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.bcbsfl.com or call the customer service phone number on your Identification Card. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

	Participating Pharmacy	**Non-Participating Pharmacy**
Pharmacy Deductible Per (BP)	$0	
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	$15	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$15	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$40	50% of the Non-Particpating Pharmacy Allowance

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	Participating Pharmacy	Non-Participating Pharmacy
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$75	50% of the Non-Particpating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$125	50% of the Non-Particpating Pharmacy Allowance

Other Important Information affecting what the Insured will pay:

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only "Participating" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- Amounts paid by us under this BlueScript Pharmacy Program will accumulate toward the lifetime maximum and/or Benefit Period maximum, as indicated on your BlueOptions Schedule of Benefits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy

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