BlueOptions

Schedule of Benefits - Plan 03900

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.bcbsfl.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

3100001104560 7R0401000000000000018289502857 1

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED) Per Person per Benefit Period	$1,500	$4,500
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	50%	50%
Out-of-Pocket Maximums Per Person per Benefit Period	$6,350	$20,000
Per Family per Benefit Period	$12,700	$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 • 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.

3100011045607R0401000000000000001629502857 2

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	$35	DED + 50%
Other health care professionals licensed to perform such Services	$50	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$200	DED + 50%
Other health care professionals licensed to perform such Services	$200	DED + 50%

Benefit Description	In-Network	Out-of-Network
Allergy Injections rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
E-Visits rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 50%	DED + 50%
Convenient Care Centers	$35	DED + 50%

3100011045607R0401000000000000016289502857 3

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by:		
1. Family Physicians	20%	DED + 50%
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	20%	DED + 50%
Out-of-pocket Maximum per Person per Month	$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.

Preventive Health Services

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

3100001104560700R0401000000000000016295028574

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)	$200	DED + 50%
All other diagnostic Services (e.g., X-rays)	DED + 50%	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	DED + 50%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 50%	DED + 50%

Outpatient Surgical Services

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

3100011045607R0401000000000000000162895028575

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out of State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	$1,500	$2,500	DED + 50% **
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Outpatient			
Facility (per visit)	$300	$400	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Therapy Services	$45	$60	DED + 50%
Emergency Room Visits			
Facility	DED + 50%		DED + 50%**
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%

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. We 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.

*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.

3100001104560 7R040100000000000001629502857 6

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health Services		
Outpatient Facility Services rendered at: Emergency Room	$0	$0
Hospital	$0	50%
Physician and other health care professionals licensed to perform such Services Family Physician office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient Facility Services	$0	50%
Physician and other health care professionals licensed to perform such Services	$0	$0

Benefit Description	In-Network	Out-of-Network
Substance Dependency Care and Treatment Services Outpatient Facility Services rendered at: Emergency Room	$0	$0
Hospital	$0	50%
Physician and other health care professionals licensed to perform such Services Family Physician Office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient Facility Services	$0	50%
Physicians and health care professionals licensed to perform such Services	$0	$0

Benefit Maximums

Unless specifically noted otherwise, benefit maximums apply per person and accumulate either on a per Benefit Period or per lifetime basis, as indicated below.

Home Health Care Visits per Benefit Period 10
Hospice (combined Inpatient, Outpatient and home) Visits/Days per Benefit Period ..... Unlimited

Inpatient Rehabilitation days per Benefit Period 30

Outpatient Therapies and Spinal Manipulations Visits (combined)
per Benefit Period 25

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Preventive Adult (17 years of age or older) Wellness Services include:

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.

Skilled Nursing Facility days per Benefit Period 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 Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums and lifetime maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums and lifetime maximums under this plan.

Prescription Drug Program

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

3100001104560 7R0401000000000000001629502857 8

BlueScript Generic Choices Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueScript Generic Choices Pharmacy Program described in the BlueScript Generic Choices Pharmacy Program Endorsement, both of which should be reviewed carefully. Prescription Drug coverage is subject to the **Exclusive Provider Provision** explained in your BlueScript Pharmacy Endorsement. If you use a Pharmacy other than a designated Exclusive Pharmacy for these Services you will be responsible for the full charge, except for Emergency Services.

For a list of Exclusive Pharmacies, or to view the Medication Guide, you may access the most recent provider directory or Generic Choices Medication Guide at www.FloridaBlue.com or call the customer service phone number on your ID Card.

BENEFIT DESCRIPTION	Retail Pharmacy (for each One-Month Supply*)	Mail Order Pharmacy (up to a Three-Month Supply)
Tier 1: Generic Prescription Drugs, insulin, Covered OTC Drugs and Covered Prescription Supplies	$10	$25
Tier 2: Brand Name Drugs indicated as covered in the Medication Guide	20% of the Exclusive Pharmacy Allowance or $50, whichever is greater**	20% of the Exclusive Pharmacy Allowance or $125, whichever is greater
Maximum Cost Share per Tier 2 Prescription	$200	$500

* 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 Exclusive Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.

** If the Exclusive Pharmacy Allowance for a Tier 2 Drug is less than $50, you will pay 100% of the Exclusive Pharmacy Allowance for that Drug.

Other Important Information affecting what you will pay:

- In order to be covered under this BlueScript Generic Choices-Pharmacy Program , Brand Name Prescription Drugs and Supplies must be indicated as covered in the Medication Guide.
- 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.
- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

3100001104560R0401000000000000018295028579

1. the Cost Share amount that applies to the Brand Name Prescription Drug you received as indicated in this Schedule of Benefits; **and**
2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug is Medically Necessary.