

### Understanding Your Share for Covered Services

This health insurance policy<sup>1</sup> has convenient copays for the most commonly used services. The coverage makes it easy to know what you'll have to spend for medical care, no matter what happens. This community-focused network helps keep your premiums down.

BlueSelect<sup>2</sup> is the Preferred Provider Network / Exclusive Provider designated as "In-Network" for BlueSelect.

Benefits for Covered Services	Amount Member Pays
<b>► Office Services</b>	
<b>Physician Office Services</b> In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	\$30 Copayment \$65 Copayment CYD <sup>3</sup> + 50% Coinsurance <sup>4</sup> \$10 Copayment CYD + 50% Coinsurance
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network	\$125 Copayment CYD + 50% Coinsurance
<b>Maternity Initial Visit – Optional Benefit Endorsement</b> With many plans a maternity option is available – you can choose to add an endorsement, at an additional rate, that provides benefits for pregnancy and delivery (the endorsement must be in effect for 30 days prior to conception).	Available
<b>Allergy Injections</b> (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	\$10 Copayment \$10 Copayment CYD + 50% Coinsurance
<b>► Preventive Care</b>	
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b> In-Network Out-of-Network Provider	\$0 50% Coinsurance
<b>Mammograms</b> In-Network and Out-of-Network	\$0
<b>Colonoscopy</b> (Routine for age 50+ then frequency schedule applies) In-Network and Out-of-Network	\$0
<b>► BlueSelect Pharmacy</b>	
For the greatest savings on your prescriptions, always check to see if the pharmacy is in the BlueSelect network. Your medication will cost you less if you stay in-network. We have identified certain drugs as a 'specialty drug'. These drugs are listed as a 'specialty drug' in the BlueSelect Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a BlueSelect Pharmacy.	
<b>Pharmacy Deductible</b>	\$300 (Brand Only)
<b>In-Network Prescription Drug Program</b> Retail and Specialty Pharmacy – Generic / Brand Mail Order (90 days) – Generic / Brand	\$10 Copayment / Brand Deductible + 50% Coins \$30 Copayment / Brand Deductible + 50% Coins
<b>Out-of-Network Prescription Drug Program</b> Retail and Specialty Pharmacy – Generic / Brand Mail Order (90 days) – Generic / Brand	50% Coinsurance / Brand Deductible + 50% Coins 50% Coinsurance / Brand Deductible + 50% Coins

1 Policies have limitations and exclusions and are medically underwritten.

2 The BlueSelect Network is our Preferred Provider/Exclusive Provider Network made up of independent hospitals, physicians and ancillary providers.

3 CYD = Calendar Year Deductible

4 Coinsurance is the percentage the member pays for service.

**Note: Out-of-Network services may be subject to balance billing.**

# BlueSelect

For Individuals Under 65

## Benefit Summary for Health Plan 117

Benefits for Covered Services

Amount Member Pays

Benefits for Covered Services	Amount Member Pays
<p><b>► BlueSelect Pharmacy (Continued)</b></p> <p>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 Deductible and the Copayment or Coinsurance applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueSelect Pharmacy Program Schedule of Benefits.</p> <p>BlueSelect Pharmacy benefit also provides coverage for Prescription oral contraceptives, Prescription diaphragms and diabetic equipment and supplies.</p> <p><b>Note: Not all Brand Name prescription drugs are covered. Please refer to the Closed Formulary Medication Guide for which Brand Name prescription drugs are covered. If you want to purchase a specific drug not listed on the Medication Guide, you will be responsible for the full cost of the drug.</b></p>	
<p><b>► Emergency Medical Care</b></p>	
<p><b>Urgent Care Centers</b> In-Network Out-of-Network</p>	<p>\$70 Copayment CYD + 50% Coinsurance</p>
<p><b>Emergency Room Facility Services (ER)<sup>5</sup></b> (per visit) In-Network Out-of-Network</p>	<p>CYD + 25% Coinsurance CYD + 25% Coinsurance</p>
<p><b>Ambulance Services</b> (In-Network and Out-of-Network) (Combined Ground travel / air and water travel, per day maximum)</p>	<p>\$5,000</p>
<p><b>► Outpatient Diagnostic Services</b></p>	
<p><b>Independent Diagnostic Testing Facility Services<sup>6</sup></b> (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (Except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT &amp; Nuclear Medicine) Out-of-Network</p>	<p>\$50 Copayment \$125 Copayment CYD + 50% Coinsurance</p>
<p><b>Outpatient Hospital Facility Services<sup>6</sup></b> (per visit) (e.g. blood work and X-rays) In-Network Out-of-Network</p>	<p>CYD + 25% Coinsurance CYD + 50% Coinsurance</p>
<p><b>► Other Provider Services</b></p>	
<p><b>Provider Services at Hospital and ER<sup>5</sup></b> In-Network and Out-of-Network</p>	<p>\$0</p>
<p><b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)</b> In-Network and Out-of-Network</p>	<p>In-Network CYD + 25% Coinsurance</p>
<p><b>Provider Services at Locations other than Office, Hospital and ER<sup>6</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network Provider</p>	<p>CYD + 25% Coinsurance CYD + 25% Coinsurance CYD + 50% Coinsurance</p>
<p><b>► Other Special Services</b></p>	
<p><b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY<sup>7</sup> max)</b> Locations other than Hospital and Physician's Office In-Network Out-of-Network Outpatient Hospital Facility (per visit) In-Network Out-of-Network</p>	<p>25 Visits \$65 Copayment CYD + 50% Coinsurance \$45 Copayment CYD + 50% Coinsurance</p>

5 Includes services rendered at a Hospital, Psychiatric Facility or Substance Abuse Facility.

6 Includes services rendered at locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or a Physician's Office.

7 PCY = Per Calendar Year

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<b>► Other Special Services (Continued)</b>	
<b>Skilled Nursing Facility (PCY max)</b> In-Network Out-of-Network	60 Days CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Hospice</b> In-Network Out-of-Network	CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>► Hospital/Surgical</b>	
<b>Ambulatory Surgical Center Facility (ASC)<sup>6</sup></b> In-Network Out-of-Network	\$250 Copayment CYD + 50% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services<sup>5</sup></b> (per admit) In-Network Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation Services limit - 21 days PCY CYD + 25% Coinsurance \$500 PAD + CYD + 50% Coinsurance
<b>Outpatient Hospital Facility Services<sup>5</sup></b> (per visit) In-Network – Therapy Services In-Network – All Other Service Out-of-Network Facility	\$45 Copayment CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>5</sup></b> (per visit) In-Network Facility Out-of-Network Facility	CYD + 25% Coinsurance CYD + 25% Coinsurance
<b>► Exclusive Provider Organization Services (EPO)</b>	
Please keep in mind that with BlueSelect there are certain services and supplies that are covered ONLY if you see the Exclusive providers within the BlueSelect network. It is very important that you consider the cost impact if you are thinking of choosing a different provider than one of the Exclusive providers designate for the following services. If you do, you will have to pay the entire bill.	
<b>Independent Clinical Lab</b> (e.g. blood work) <sup>6</sup> In-Network Out-of-Network	\$0 <b>No Coverage</b>
<b>Mental Health</b> (PCY Max; inpatient/outpatient) <b>Substance Dependency</b> (PCY Max; inpatient/outpatient) Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network Provider Services a Hospital and ER In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network Outpatient Office Visit In-Network Family Physician In-Network Specialist Out-of-Network	30 days/20 visits InPat Detox Only; 20 OP visits  \$600 Copayment <b>No Coverage</b>  \$0 <b>No Coverage</b>  \$300 Copayment <b>No Coverage</b>  \$30 Copayment \$65 Copayment <b>No Coverage</b>
<b>Durable Medical Equipment, Prosthetics and Orthotics<sup>5</sup></b> In-Network Out-of-Network	\$0 <b>No Coverage</b>
<b>Home Health Care</b> In-Network Out-of-Network	\$0 <b>No Coverage</b>

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<b>► Financial Features</b>	
<b>Calendar Year Deductible CYD</b> (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	\$3,000 / N/A \$5,000 / N/A
<b>Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$500
<b>Coinsurance</b> In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	25% / 50%
<b>Out-of-Pocket Maximum</b> (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD; Excludes Prescription Drugs. The In-Network Out-of-Pocket Maximum and Out-of-Network Out-of-Pocket Maximum are separate, and as such, accumulate separately and are applied separately.) (Any non-covered charges, benefit penalty reductions, charges in excess of any maximum benefit limitations, or charges in excess of the Allowed Amount are not included.)	\$7,500 / \$15,000 \$25,000 / \$25,000
<b>Total Lifetime Maximum Benefit</b> (per member)	No Maximum

For added peace of mind, your dependents may be covered as long as you maintain your BlueSelect policy with us. Ask for complete details since some restrictions apply.

### Exclusive Providers within the BlueSelect network.

You do not need a referral to receive care from a BlueSelect provider. However, please remember that if you do not receive care from an Exclusive Provider for the services identified below, you will be responsible for the full charge (except in certain situations such as emergencies). It pays to stay in-network and use an Exclusive Provider for covered:

- **Clinical Laboratory Tests** ordered by a doctor (no cost to you)
- **Home Health Services** such as visiting nurses, physical therapy, speech-language therapy, and occupational therapy (no cost to you)
- **Behavioral Health Care and Substance Dependency Services**
- **Durable Medical Equipment and Medical Supplies** that a provider may order as part of treatment or supplied as a service (no cost to you)

### BlueSelect pharmacy options.

There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—**retail pharmacies and specialty pharmacies**. To be covered under your pharmacy program at the lowest cost, before you get a prescription filled you should **confirm which pharmacy is considered ‘in-network’ for that particular medication**. We encourage you to go to our online provider directory to locate an in-network pharmacy for your particular medication.

### Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual BlueSelect Contract. For a complete description of benefits and exclusions, please see the BlueSelect Contract.

- All services not specifically listed in the Contract or in any rider or endorsement, unless such services are specifically required by state law
- Any service which is not Medically Necessary
- Maternity care
- Elective cosmetic surgery
- Hearing aids or eyeglasses, vision or dental care, or oral appliances
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care

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Services subject to an Exclusive Provider Provision rendered or supplied by any Provider **other than the Provider designated solely by us as the Exclusive Provider of such services**, except for Emergency Services and Care for the treatment of an Emergency Medical Condition. Please refer to your Schedule of Benefits to determine which services are subject to an Exclusive Provider Provision.

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual BlueSelect Contract for details. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida, Inc. (BCBSF), an independent licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract.

### Important information regarding BlueSelect coverage

Certain services, such as Advanced Imaging Services and Specialty Drugs, require prior authorization before obtaining the service. While it is your responsibility to confirm the network participation status of a provider before you receive the service, it is the provider's responsibility to obtain the prior authorization. If there is no prior authorization on file, it will result in the claim being denied. If you choose to see a non-participating provider for certain services such as Advanced Imaging Services, you may have an obligation to ensure an authorization is on file to receive full coverage for the service. Please see your Contract to understand when you may need to take steps to ensure full benefit access.

**You have the right to appeal:** BCBSF has a quality assurance program in place to assess the services of Exclusive providers. Quality assurance includes formal review of care, problem identification, corrective actions and evaluation of actions taken.

**How to Appeal an Adverse Benefit Determination or a Grievance:** You have the right to appeal an Adverse Benefit Determination or file a Grievance with us. Your appeal or grievance will be reviewed using the review process described in your contract. It must be submitted to us in writing for an internal appeal within 365 days of the original appeal. But if it's a Concurrent Care Decision, it may require you to file within a shorter period of time from notice of the denial.

**Subscriber Assistance Program:** The Subscriber Assistance Program (SAP) is a State of Florida program available to assist you with grievances that have not been satisfactorily resolved.