

# BlueOptions

For Individuals Under 65

## Benefit Summary for Health Plan 0598 – Health with dental benefits



### 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. Plus, the plan comes with benefits for routine dental care.

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

#### Benefits for Covered Services

#### Amount Member Pays

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	\$35 Copayment \$50 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 Medicine) In-Network Out-of-Network	\$200 Copayment CYD + 50% Coinsurance
<b>Maternity Initial Visit</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).	Not Covered (Rider 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>Medical Pharmacy – Physician-Administered Medications</b> (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum <sup>5</sup> In-Network Out-of-Network	\$200 20% Coinsurance CYD + 50% Coinsurance
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your medical benefit. <b>Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.</b>	
<b>► Preventive Care</b>	
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b> In-Network Out-of-Network	\$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

1 Policies have limitations and exclusions and are medically underwritten.

2 NetworkBlue is one of our Preferred Provider Networks made up of independent hospitals, physicians and ancillary providers.

3 CYD = Calendar Year Deductible

4 Coinsurance is the percentage the member pays for service.

5 In-Network Medical Pharmacy will be paid at 100% for remainder of calendar month once Out-of-Pocket Maximum is met.

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

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## Benefits for Covered Services

## Amount Member Pays

<p><b>► Prescription Drug Program (BlueScript)<sup>®</sup></b></p> <p>For the greatest savings on your prescriptions, always check to see if the pharmacy is in-network for your BlueOptions plan. 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 Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy.</p>	
<b>Pharmacy Deductible (PD)</b>	\$0
<p><b>In-Network Prescription Drug Program</b> Retail and Specialty Pharmacy – Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred</p>	\$10 Copayment / Not Covered \$25 Copayment / Not Covered
<p><b>Out-of-Network Prescription Drug Program</b> Retail and Specialty Pharmacy - Generic / Brand and Non-Preferred Mail Order (90 days) – Generic / Brand and Non-Preferred</p>	50% Coinsurance / Not Covered 50% Coinsurance / Not Covered
<p><b>BlueScript Pharmacy benefit also provides coverage for Generic Prescription oral contraceptives, Generic Prescription diaphragms and diabetic equipment and supplies.</b></p>	
<p><b>► Emergency Medical Care</b></p>	
<p><b>Urgent Care Centers</b> In-Network Out-of-Network</p>	\$55 Copayment CYD + 50% Coinsurance
<p><b>Emergency Room Facility Services (ER)<sup>7</sup></b> (per visit) In-Network Out-of-Network</p>	\$300 Copayment \$300 Copayment
<p><b>Ambulance Services</b> (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network</p>	\$5,000 In-Network CYD + 25% Coinsurance
<p><b>► Outpatient Diagnostic Services</b></p>	
<p><b>Independent Diagnostic Testing Facility Services<sup>8</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 and Nuclear Medicine) Out-of-Network</p>	\$50 Copayment \$200 Copayment CYD + 50% Coinsurance
<p><b>Independent Clinical Lab<sup>8</sup></b> (e.g. blood work) In-Network / Out-of-Network</p>	\$ 0 Copayment / CYD + 50% Coinsurance
<p><b>Outpatient Hospital Facility Services<sup>7</sup></b> (per visit) (e.g. blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network</p>	CYD + 25% Coinsurance CYD + 50% Coinsurance
<p><b>► Mental Health/Substance Dependency</b></p>	
<p><b>Mental Health</b> (Inpatient PCY<sup>6</sup> / Outpatient PCY) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network</p>	8 days / 8 visits CYD + 25% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance \$50 Copayment CYD + 50% Coinsurance
<p><b>Substance Dependency</b> Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network</p>	CYD + 25% Coinsurance \$500 PAD PAD + CYD + 50% Coinsurance \$50 Copayment CYD + 50% Coinsurance

6 PCY = Per Calendar Year

7 Includes services rendered at a Hospital, Psychiatric Facility or Substance Abuse Facility. Please refer to the Provider Directory to determine the applicable option for each In-Network Hospital. Services rendered at an Out-of-State BlueCard<sup>®</sup> Program participating hospital are at the Option 2 In-Network cost sharing amount.

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

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## Benefits for Covered Services

## Amount Member Pays

Benefits for Covered Services		Amount Member Pays
<b>► Other Provider Services</b>		
<b>Provider Services at Hospital and ER<sup>7</sup></b> In-Network / Out-of-Network		In-Network CYD + 25% Coinsurance
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center</b> In-Network / Out-of-Network		In-Network CYD + 25% Coinsurance
<b>Provider Services at Locations other than Office, Hospital and ER<sup>8</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network		CYD + 25% Coinsurance CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>► Other Special Services</b>		
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max)</b> Locations other than Hospital and Physician's Office In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network		35 visits  CYD + 25% Coinsurance CYD + 50% Coinsurance  CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Durable Medical Equipment, Prosthetics and Orthotics<sup>7</sup></b> In-Network Out-of-Network		CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Home Health Care (PCY max)</b> In-Network Out-of-Network		10 visits CYD + 25% Coinsurance CYD + 50% Coinsurance
<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>8</sup></b> In-Network / Out-of-Network		CYD + 25% Coinsurance / CYD + 50% Coinsurance
<b>Provider Services Rendered at an ASC<sup>8</sup></b> In-Network Family Physician In-Network Specialist Out-of-Network		CYD + 25% Coinsurance CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services<sup>7</sup> (per admit)</b> In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network		Rehabilitation limit PCY - 21 days CYD + 25% Coinsurance \$500 PAD + CYD + 50% Coinsurance
<b>Outpatient Hospital Facility Services<sup>8</sup> (per visit)</b> In-Network – Therapy Services (Option 1 / Option 2) In-Network – All Other Services (Option 1 / Option 2) Out-of-Network Facility		\$55 Copayment / \$70 Copayment CYD + 25% Coinsurance CYD + 50% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>7</sup> (per visit)</b> In-Network / Out-of-Network		\$300 Copayment

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## Benefits for Covered Services

## Amount Member Pays

► Financial Features	
<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 / NA \$6,000 / NA
<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>Lifetime Maximum Benefit (per person)</b>	No Maximum

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

## Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual BlueOptions Contract. For a complete listing, please refer to the 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

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual BlueOptions 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., an Independent Licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract. For a complete description of benefits and exclusions, please see the Contract.

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## Understanding Your Share for Covered Dental Expenses

Benefits for Covered Services	Amount Member Pays
<b>Calendar Year Deductible<sup>9</sup></b> (per person/family aggregate) In-Network <sup>10</sup> and Out-of-Network	Basic Services only \$75 / \$225
<b>Preventive Services</b> In-Network <sup>10</sup> and Out-of-Network (Including Periodic oral evaluation, Bitewings—two films, Cleaning—Adult/Child, Fluoride Treatment (Child only))	No Waiting Period \$0
<b>Basic Services</b> In-Network <sup>10</sup> and Out-of-Network (Including Amalgam Restorations (Silver fillings), Extractions—Routine and Surgical, Intraoral—complete series (including bitewings), Resin—based composite one surface, posterior)	No Waiting Period CYD + 20% Coinsurance <sup>11</sup>
<b>Plan Year Maximum Benefits<sup>10</sup></b> (per member)	\$750

## Dental Limitations and Exclusions

### Limitations:

- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- Sealants are limited to the first and second molars for primary teeth and the bicuspid and molars for the permanent teeth of covered dependent children.
- Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.

### Exclusions:

- Veneer restorations
- Services rendered primarily for cosmetic purposes
- General anesthesia and intravenous sedation
- Charges for nitrous oxide
- Implant services
- Orthodontia services
- Major services including, but not limited to, dentures (full, partial and replacement), bridges (including pontics, and abutment crowns—new or replacement), inlays and onlays, partials (new or replacement)

<sup>9</sup> CYD and maximum benefits for Dental Services are separate from Health Services CYD and maximum benefits, and as such accumulates separately.

<sup>10</sup> Networks are comprised of independent contracted dentists.

<sup>11</sup> Coinsurance is the percentage of the Fee Schedule the member pays for services.