

**Summary of 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	\$25 Copayment \$45 Copayment Not Covered \$10 Copayment Not Covered
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Medicine) In-Network Out-of-Network	\$125 Copayment Not Covered
<b>Maternity Initial Visit</b> In-Network Family Physician In-Network Specialist Out-of-Network	\$25 Copayment \$45 Copayment Not Covered
<b>Allergy Injections</b> (per visit) In-Network Out-of-Network	\$10 Copayment Not Covered
<b>Medical Pharmacy - Physician-Administered Medications</b> (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum <sup>1</sup> Preferred Non-Preferred In-Network Provider Preferred Non-Preferred Out-of-Network	\$200 \$700  15% Coinsurance 35% Coinsurance Not Covered
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 <i>medical</i> 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>Convenient Care Centers</b> In-Network Out-of-Network	\$25 Copayment Not Covered
<b>Preventive Care</b>	
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b> In-Network Out-of-Network	\$0 Not Covered
<b>Mammograms</b> In-Network Out-of-Network	\$0 Not Covered
<b>Colonoscopy</b> (Routine for age 50+ then frequency schedule applies) In-Network Out-of-Network	\$0 Not Covered
<b>Emergency Medical Care</b>	
<b>Urgent Care Centers</b> In-Network Out-of-Network	\$45 Copayment Not Covered

<sup>1</sup> In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met. Florida Blue HMO is the trade name of Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.

# BlueCare

## For Large Groups

### Health Benefit Plan 60

#### Summary of Benefits for Covered Services

*Amount Member Pays*

<b>Emergency Medical Care (Continued)</b>	
<b>Emergency Room Facility Services</b> (per visit) (copayment waived if admitted) In-Network and Out-of-Network	\$100 Copayment
<b>Ambulance Services</b> In-Network Out-of-Network (Emergency Services Only)	DED <sup>2</sup> +10% Coinsurance DED +10% Coinsurance
<b>Outpatient Diagnostic Services</b>	
<b>Independent Diagnostic Testing Center Services</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, Nuclear Medicine) Out-of-Network	\$45 Copayment \$80 Copayment Not Covered
<b>Independent Clinical Lab</b> (e.g. Blood Work) In-Network Out-of-Network	\$0 Not Covered
<b>Outpatient Hospital Facility Services</b> (per visit) (e.g. Blood Work and X-rays) In-Network Out-of Network	\$275 Copayment Not Covered
<b>Other Provider Services</b>	
<b>Provider Services at Hospital and ER</b> In-Network Out-of-Network ER Out-of-Network Hospital	\$0 \$0 Not Covered
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)</b> In-Network Specialist Out-of-Network	\$0 Not Covered
<b>Provider Services at Locations other than Office, Hospital and ER</b> In-Network Family Physician In-Network Specialist Out-of-Network	\$25 Copayment \$45 Copayment Not Covered
<b>Other Special Services</b>	
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations</b> (PBP <sup>3</sup> Max) Outpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network	30 Visits \$45 Copayment Not Covered \$65 Copayment Not Covered
<b>Durable Medical Equipment, Prosthetics and Orthotics</b> In-Network Out-of-Network	DED + 10% Coinsurance Not Covered
<b>Home Health Care</b> (PBP Max) In-Network Out-of-Network	60 Visits \$0 Not Covered
<b>Skilled Nursing Facility</b> (PBP Max) In-Network Out-of-Network	45 days DED + 10% Coinsurance Not Covered

<sup>2</sup> DED = Deductible

<sup>3</sup> PBP = Per Benefit Period

# BlueCare

## For Large Groups

### Health Benefit Plan 60

#### Summary of Benefits for Covered Services

*Amount Member Pays*

<b>Other Special Services (Continued)</b>	
<b>Hospice</b> In-Network Out-of-Network	DED + 10% Coinsurance Not Covered
<b>Hospital / Surgical</b>	
<b>Ambulatory Surgical Center Facility (ASC)</b> In-Network Out-of-Network	\$200 Copayment Not Covered
<b>Inpatient Hospital Facility and Rehabilitation Services</b> (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 30 days \$325 Copayment per day / \$1,625 Maximum Not Covered
<b>Outpatient Hospital Facility Services</b> (per visit) In-Network – Therapy Services In-Network – All other Services Out-of-Network	\$65 Copayment \$275 Copayment Not Covered
<b>Emergency Room Facility Services</b> (per visit) (copayment waived if admitted) In-Network and Out-of-Network	\$100 Copayment
<b>Mental Health / Substance Dependency</b>	
<b>Inpatient Hospitalization Facility Services<sup>4</sup></b> (per admit) In-Network Out-of-Network	\$0 Not Covered
<b>Outpatient Hospitalization Facility Service</b> (per visit) In-Network Out-of-Network	\$0 Not Covered
<b>Emergency Room Facility Services</b> (per visit) In-Network and Out-of-Network	\$0
<b>Provider Services at Hospital and ER</b> In-Network Family Physician / Specialist Out-of-Network ER Out-of-Network Hospital	\$0 \$0 Not Covered
<b>Provider Services at Locations other than Office, Hospital and ER</b> In-Network Family Physician / Specialist Out-of-Network	\$0 Not Covered
<b>Outpatient Office Visit</b> In-Network Family Physician / Specialist Out-of-Network	\$0 Not Covered
<b>Financial Features</b>	
<b>Deductible (DED)</b> (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue HMO pays)	\$500 / \$1,000 Not Covered
<b>Coinsurance</b> In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	10% Not Covered

<sup>4</sup> Inpatient Substance Dependency Treatment is limited to Detoxification only

# BlueCare

## For Large Groups

### Health Benefit Plan 60

#### Summary of Benefits for Covered Services

*Amount Member Pays*

<b>Financial Features (Continued)</b>	
<b>Out-of-Pocket Maximum (PBP)</b> (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$3,500 / \$7,000 Not Covered
<b>Total Lifetime Maximum Benefit</b>	No Maximum

#### Additional Benefits and Features

##### BlueCare Rx Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue HMO, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

##### An Array of Value-Added Programs and Services

- **Access to valuable health information and resources**, including care decision support, our online provider directory at [floridablue.com](http://floridablue.com) and other interactive web-based support tools.
- **Expert advice on call.** We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- Online access to everything about your health benefit plan as well as all of our self-service tools.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.\*
- BlueCare members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

**Preauthorization for select services:** You don't need a referral to see a participating specialist, however authorizations are required for certain office-based services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment.

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

\* As a courtesy, Florida Blue has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.