

Amount Member Pays

In-Network

Out-of-Network

**Summary of Benefits for Covered Services**

<b>Financial Features</b>		
<b>Deductible</b> (DED <sup>1</sup> ) (PBP <sup>2</sup> ) (DED is the amount the member is responsible for before Florida Blue HMO pays)	\$2,000 per person \$6,000 per family	Not covered
<b>In-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$100	Not Applicable
<b>Coinsurance</b> (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	Not covered
<b>Out-of-Pocket Maximum</b> (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$5,500 per person \$11,000 per family	Not covered
<b>Office Services</b>		
<b>Physician Office Services</b> Value Choice Provider (in select counties) Primary Care Physician Specialist Convenient Care	\$0 Copay \$35 Copay \$65 Copay \$35 Copay	Not covered Not covered Not covered Not covered
<b>Virtual Visits</b> Family Physician/Specialist	\$10 Copay/\$65 Copay	Not covered
<b>Maternity</b> (Cost Share for initial visit only) Primary Care Physician Specialist	\$35 Copay \$65 Copay	Not covered Not covered
<b>Allergy Injections</b> (per visit) Primary Care Physician Specialist	\$10 Copay \$10 Copay	Not covered Not covered
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Med.)	\$300 Copay	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>3</sup> Preferred Non-Preferred  Provider Preferred Non-Preferred	\$200 Combined with Preferred OOP Maximum  20% 20%	   Not covered 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 the <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>Preventive Care</b>		
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b>	\$0	Not covered
<b>Mammograms (Routine &amp; Diagnostic)</b>	\$0	Not covered
<b>Colonoscopy</b> (Routine for age 50+; no age criteria for high risk)	\$0	Not covered

<sup>1</sup> DED = Deductible

<sup>2</sup> PBP = Per Benefit Period

<sup>3</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 a trade name of Health Options, Inc., an HMO affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. Florida Blue HMO does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

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<b>Emergency Medical Care</b>		
<b>Urgent Care Centers</b>	\$50 Copay	Not covered
<b>Emergency Room Facility Services</b> (per visit) (copayment waived if admitted)	\$300 Copay	\$300 Copay
<b>Ambulance Services</b>	20% after Deductible	20% after In-Network Deductible
<b>Outpatient Diagnostic Services</b>		
<b>Independent Diagnostic Testing Facility Services</b> (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	\$50 Copay	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$300 Copay	Not covered
<b>Independent Clinical Lab</b> (e.g., Blood Work) Quest Diagnostics is preferred lab	\$0	Not covered
<b>Outpatient Hospital Facility Services</b> (per visit) (e.g., Blood Work and X-rays)	20% after Deductible	Not covered
<b>Hospital / Surgical</b>		
<b>Ambulatory Surgical Center Facility (ASC)</b>	\$250 Copay	Not covered
<b>Outpatient Hospital Facility Services</b> (per visit)		
Therapy Services	\$65 Copay	Not covered
All other Services	20% after Deductible	Not covered
<b>Inpatient Hospital Facility and Rehabilitation Services</b> (per admit)	\$100 PAD, then 20% after Deductible	Not covered
<b>Mental Health / Substance Dependency</b>		
<b>Inpatient Hospitalization Facility Services</b> (per admit)	\$100 PAD, then 20% after Deductible	Not covered
<b>Outpatient Hospitalization Facility Service</b> (per visit)	20% after Deductible	Not covered
<b>Emergency Room Facility Services</b> (per visit)	\$300 Copay	\$300 Copay
<b>Provider Services at Hospital</b>		
Primary Care Physician / Specialist	\$0	Not covered
<b>Provider Services at ER</b>		
Primary Care Physician / Specialist	\$0	\$0
<b>Provider Services at Locations other than Office, Hospital and ER</b>		
Primary Care Physician / Specialist	\$35 Copay	Not covered
<b>Outpatient Office Visit</b>		
Primary Care Physician / Specialist	\$35 Copay	Not covered
<b>Other Provider Services</b>		
<b>Provider Services at Hospital</b>	20% after Deductible	Not covered
<b>Provider Services at ER</b>	20% after Deductible	20% after In-Network Deductible
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)</b>	\$65 Copay	Not covered
<b>Provider Services at Locations other than Office, Hospital and ER</b>		
Primary Care Physician	\$35 Copay	Not covered
Specialist	\$65 Copay	Not covered
<b>Other Special Services</b>		
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations</b>		
Outpatient Rehabilitation Therapy Center	\$65 Copay	Not covered
Outpatient Hospital Facility Services (per visit)	\$65 Copay	Not covered

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**Summary of Benefits for Covered Services**

<b>Other Special Services (continued)</b>		
<b>Durable Medical Equipment, Prosthetics and Orthotics</b>		
Motorized Wheelchair	\$500 Copay	Not covered
All Other (Services coordinated by CareCentrix, call 1-877-561-9910)	\$0	Not covered
<b>Home Health Care</b> (Services coordinated by CareCentrix, call 1-877-561-9910)	\$0	Not covered
<b>Skilled Nursing Facility</b>	20% after Deductible	Not covered
<b>Hospice</b>	20% after Deductible	Not covered
<b>Bariatric Surgery: Effective 1/1/2020 only Gastric Sleeve covered. Special Guidelines apply. Contact Patty Nguyen, Florida Blue On-site Rep. at 1-904-635-9221 for details.</b>		

**Preauthorization for select services:** Members don't need a referral to see a participating specialist, however authorizations are required for certain 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. Ensure members know that **before an appointment** they should visit [floridablue.com/Authorization](http://floridablue.com/Authorization) or call the toll-free number on their member ID card to see if a prior authorization is required.

<b>Benefit Maximums</b>	
<b>Home Health Care</b>	20 Visits PBP
<b>Inpatient Rehabilitation Therapy</b>	30 Days PBP
<b>Outpatient Therapy</b>	35 Visits PBP
<b>Spinal Manipulations</b>	26 PBP (accumulates towards the Outpatient Therapy maximum)
<b>Skilled Nursing Facility</b>	60 Days PBP

**Additional Benefits and Features**

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at [floridablue.com](http://floridablue.com).
- Go to [floridablue.com](http://floridablue.com), click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

**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.

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

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.