

BlueChoice
For Large Groups
Family Physician Benefit Plan 317



Summary of Benefits for Covered Services Amount Member Pays
In-Network Out-of-Network

Financial Features		
Deductible (EM DED) ¹ (PBP) ² (DED is the amount the member is responsible for before Florida Blue pays)	\$500 per person \$1,500 per family	Combined with In-Network Combined with In-Network
Inpatient Hospital Facility Services Per Admission Deductible (PAD)	\$0	\$300
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (EM OOP) ³ (PBP) (Out-of-Pocket Maximum includes Coinsurance)	\$2,000 per person \$6,000 per family	Combined with In-Network Combined with In-Network
Office Services		
Virtual Visits⁴ Primary Care Physician Specialist	\$20 Copay DED + 20%	Not Covered Not Covered
Physician Office Services Value Choice Primary Care Physician ⁵ Value Choice Specialist ⁵ Primary Care Physician Specialist	\$20 Copay DED + 20% \$20 Copay DED + 20%	DED + 40% DED + 40% DED + 40% DED + 40%
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	\$20 Copay DED + 20%	DED + 40% DED + 40%
Allergy Injections (per visit) Primary Care Physician Specialist	\$5 Copay DED + 20%	DED + 40% DED + 40%
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 20%	DED + 40%

¹EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan. / ²PBP = Per Benefit Period / ³EM OOP = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan. / ⁴Virtual Visit services are only covered for In-Network providers. / ⁵Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / ⁶In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

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

Amount Member Pays

In-Network Out-of-Network

Summary of Benefits for Covered Services	In-Network	Out-of-Network
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	\$20 Copay	DED + 40%
Mammograms	\$0 Copay	\$0 Copay
Colonoscopy (Routine for age 50+ then frequency schedule applies)	DED + 20%	DED + 40%
Emergency Medical Care		
Urgent Care Centers Value Choice Provider ⁵ All Other Providers	\$20 Copay \$20 Copay	DED + \$20 DED + \$20
Emergency Room Facility Services⁷ (per visit) (cost share waived if admitted)	DED + 20%	INN DED + 20%
Ambulance Services	DED + 20%	INN DED + 20%
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 20%	DED + 40%
	DED + 20%	DED + 40%
Independent Clinical Lab (e.g., Blood Work)	20%	40%
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	DED + 20%	DED + 40%
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	DED + 20%	DED + 40%
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	DED + 20%	DED + 40%
	DED + 20%	DED + 40%
Inpatient Hospital Facility and Rehabilitation Services⁷ (per admit)	DED + 20%	\$300 PAD, then DED + 40%

⁵Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / ⁷If admitted as an Inpatient from the Emergency Room member pays the In-Network Hospital cost share.

Mental Health / Substance Dependency		
Virtual Visits⁴ Primary Care Physician Specialist	\$0 Copay \$0 Copay	Not Covered Not Covered
Physician Office Services Primary Care Physician Specialist	\$0 Copay \$0 Copay	40% 40%
Emergency Room Facility Services⁷ (per visit) (cost share waived if admitted)	\$0 Copay	\$0 Copay
Outpatient Hospitalization Facility Service (per visit)	\$0 Copay	40%
Inpatient Hospitalization Facility Services⁷ (per admit)	\$0 Copay	40%
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	DED + 20% DED + 20%	DED + 40% DED + 40%
Durable Medical Equipment, Prosthetics and Orthotics	DED + 20%	DED + 40%
Home Health Care	DED + 20%	DED + 40%
Skilled Nursing Facility	DED + 20%	DED + 40%
Hospice	\$0 Copay	\$0 Copay

⁴Virtual Visit services are only covered for In-Network providers. / ⁷If admitted as an Inpatient from the Emergency Room member pays the In-Network Hospital cost share.

Benefit Maximums	
Inpatient Rehabilitation Therapy	21 Days PBP
Home Health Care	20 Visits PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	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.
- Let our members know they can go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in the plan's network and they don't need a referral to see a participating provider.

MediScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, 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.

The BlueChoice® health benefit plan your employer is offering you is paired with our MediScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain Prescription Drugs at a location convenient to you.

Your MediScript pharmacy benefit provides coverage for prescription drugs, oral contraceptives and diaphragms. When purchasing prescription drugs, you will need to pay for the medication at the pharmacy and then file a claim for reimbursement. Any covered prescription filled at a pharmacy and submitted for reimbursement as a claim will apply to your deductible.

Upon meeting your deductible through a combination of health and/or pharmacy claims, you will receive reimbursement for your pharmacy claims at the lower coinsurance percentage. The coinsurance percentage shown in the table below is the amount Florida Blue pays based on the allowed amount.

See below for your specific plan details.

MediScript Retail Pharmacy Program

- Participating Pharmacy 80% reimbursement after INN DED
- Maximum Supply 31 days
- Oral Contraceptives and Devices Covered

Mail Order Pharmacy Program

- Generic Drugs \$14 copay
- Brand Drugs \$28 copay
- Maximum Supply 93 days
- Oral Contraceptives and Devices Covered
- Diabetic supplies such as lancets and chemstrips Covered

This is not an insurance contract or Certificate of Coverage. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueChoice Benefit Booklet and Schedule of Benefits; its terms prevail.