# BlueChoice

## Schedule of Benefits - Plan 317

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- References to Deductible are abbreviated as "**DED**" and references to Benefit Period are abbreviated as "**BP**".

**Your Benefit Period (BP)** ..... **01/01 – 12/31**

| DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Deductible (DED) - Embedded*** Per Person per BP | $500 Combined with INN | |
| Per Family per BP | $1,500 Combined with INN | |
| **Per Admission Deductible (PAD)** | $0 | $300 |
| **Emergency Room Per Visit Deductible (PVD)** | $0 | $0 |
| **Coinsurance** (The percentage of the Allowed Amount **you pay** for Covered Services) | 20% | 40% |
| **Out-of-Pocket Maximums - Embedded*** Per Person per BP | $2,000 Combined with INN | |
| Per Family per BP | $6,000 Combined with INN | |

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

*Refer to the YOUR SHARE OF HEALTH CARE EXPENSES section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Out-Of-Pocket Maximums amounts are satisfied.

What **applies** to out-of-pocket maximums?

- Coinsurance

What **does not apply** to out-of-pocket maximums?

- Charges for non-covered Services
- Charges in excess of the Allowed Amount
- Any benefit penalty reductions
- DED
- PAD, if applicable
- PVD, if applicable
- Copayments
- Any Prescription Drug Cost Share amounts (except for Medical Pharmacy Services)

## Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copay is listed in the charts that follow, the Copay applies per visit.

| OFFICE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Office Visits rendered by** Primary Care Physicians | $20 Copay | DED + 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |
| **Allergy Injections rendered by** Primary Care Physicians | $5 Copay | DED + 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |
| **Advanced Imaging Services** (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) **rendered by** Primary Care Physicians | $20 Copay | DED + 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |

| OFFICE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **E-Visits rendered by** Primary Care Physicians | $20 Copay | DED + 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | DED +20% | DED + 40% |
| **Outpatient Therapies and Spinal Manipulation rendered by** Primary Care Physicians | $20 Copay | DED + 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |

| PREVENTIVE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Adult Wellness Services rendered by** Primary Care Physicians | $20 Copay | 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | 20% | 40% |
| **Adult Well Woman Services rendered by** Primary Care Physicians | $20 Copay | 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | 20% | 40% |
| **Child Health Supervision Services rendered by** Primary Care Physicians | $20 Copay | 40% |
| Specialist Physicians and other health care professionals licensed to perform such Services | 20% | 40% |
| **Colonoscopies** (Routine and Diagnostic) | DED + 20% | DED + 40% |
| **Mammograms** | $0 Copay | $0 Copay |

| OUTPATIENT DIAGNOSTIC SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Independent Clinical Lab** | 20% | 40% |
| **Independent Diagnostic Testing Facility**<br>Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | DED + 20% | DED + 40% |
| All other diagnostic Services (e.g., X-rays) | DED + 20% | DED +40% |
| **Outpatient Hospital Facility** | DED + 20% | DED + 40% |

| EMERGENCY AND URGENT CARE SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Ambulance Services** | DED + 20% | DED + 20% |
| **Convenient Care Centers** | $20 Copay | DED + 40% |
| **Emergency Room Visits**<br>Facility | DED + 20% | DED + 20% |
| Physician Services | DED + 20% | DED + 20% |
| **Urgent Care Center** | $20 Copay | DED + $20 Copay |

| OUTPATIENT SURGICAL SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Ambulatory Surgical Center**<br>Facility (per visit) | DED + 20% | DED + 40% |
| Radiologists, Anesthesiologists, and Pathologists | DED + 20% | DED + 40% |
| Other health care professional Services rendered by all other Providers | DED + 20% | DED + 40% |
| **Outpatient Hospital Facility** | DED + 20% | DED + 40% |

| HOSPITAL SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Inpatient**<br>Facility Services (per admission) | DED + 20% | PAD + DED + 40% |
| Physician and other health care professional Services | DED + 20% | DED + 40% |
| **Outpatient**<br>Facility (per visit) | DED + 20% | DED + 40% |
| Physician and other health care professional Services | DED + 20% | DED + 40% |
| Therapy Services | DED + 20% | DED + 40% |
| **Emergency Room Visits**<br>Facility | DED + 20% | DED + 20% |
| Physician and other health care professional Services | DED + 20% | DED + 20% |

**Important:**

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room Physicians. Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) will be covered at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

| MENTAL HEALTH AND SUBSTANCE DEPENDENCY TREATMENT SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Inpatient Hospital, Psychiatric or Substance Abuse Facility Services** | $0 Copay | 40% |
| **Outpatient Facility Services rendered at** Emergency Room | $0 Copay | $0 Copay |
| Hospital, Psychiatric or Substance Abuse Facility | $0 Copay | 40% |
| **Physician and other health care professionals licensed to perform such Services rendered at** Primary Care Physician Office | $0 Copay | 40% |
| Specialist Office | $0 Copay | 40% |
| Emergency Room | $0 Copay | $0 Copay |
| Hospital, Psychiatric or Substance Abuse Facility | $0 Copay | $0 Copay |
| Primary Care Physician at all other locations | $0 Copay | 40% |
| Specialist at all other locations | $0 Copay | 40% |

| OTHER SERVICES | IN-NETWORK (INN) | OUT-OF-NETWORK (OON) |
|---|---|---|
| **Birth Center** | DED + 20% | DED + 40% |
| **Dialysis Center** | DED + 20% | DED + 40% |
| **Durable Medical Equipment** | DED + 20% | DED + 40% |
| **Enteral Formula** | DED + 20% | DED + 40% |
| **Home Health Services** | DED + 20% | DED + 40% |
| **Hospice Services** - Inpatient, Outpatient and Home | $0 Copay | $0 Copay |
| **Outpatient Rehabilitation Facility** | DED + 20% | DED + 40% |
| **Prosthetic and Orthotic Devices** | DED + 20% | DED + 40% |
| **Skilled Nursing Facility** | DED + 20% | DED + 40% |

## BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

**Home Health Care** visits ..... 20

**Hospice** (Combined Inpatient, Outpatient and Home) per Covered Plan Participant per Lifetime. Unlimited

**Inpatient Rehabilitative Care** Days per Covered Plan Participant ..... 21

**Outpatient Therapies and Spinal Manipulation** visits (combined) ..... 35

**Note:** Spinal Manipulations are limited to 26 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

**Skilled Nursing Facility** days ..... 60

**Benefit Maximum Carryover**

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by Florida Blue or Florida Blue HMO to the Group, amounts applied to your Benefit Period maximums under the prior Florida Blue or Florida Blue HMO policy will be applied toward your Benefit Period maximums under this plan.