

BlueOptions with Integrated Prescription Drug Coverage

Schedule of Benefits - Plan 05193 Family Coverage

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider’s participation status prior to receiving Health Care Services. To verify a Provider’s specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as “DED”.
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period..... 01/01 – 12/31

Deductible, Coinsurance and Out-of-Pocket Maximums

| Benefit Description | In-Network | Out-of-Network |
|--|----------------|----------------|
| Deductible (DED) - Shared* | | |
| Per Person per Benefit Period | \$5,000 | \$10,000 |
| Per Family per Benefit Period | \$5,000 | \$10,000 |
| Per Admission Deductible (PAD) | Not Applicable | \$500 |
| Coinsurance - The percentage of the Allowed Amount you pay for Covered Services | 20% | 40% |
| Out-of-Pocket Maximums - Embedded* | | |
| Per Person per Benefit Period | \$6,850 | \$23,200 |
| Per Family per Benefit Period | \$11,600 | \$23,200 |

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 DED and Out-of-Pocket Maximum amounts.

*Refer to the Understanding 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?

- DED
- PAD, when applicable
- Coinsurance
- Copayments
- Any Prescription Drug Cost Share amounts

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

- Non-covered charges
- Any benefit penalty reductions
- Charges in excess of the Allowed Amount

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.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

| Benefit Description | In-Network | Out-of-Network |
|---|------------|----------------|
| Office Visits rendered by Family Physicians | DED + 20% | DED + 40% |
| Other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |
| Allergy Injections rendered by Family Physicians | DED + 20% | DED + 40% |
| 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 cardiology) rendered by Family Physicians | DED + 20% | DED + 40% |
| Other health care professionals licensed to perform such Services. | DED + 20% | DED + 40% |
| E-Visits rendered by Family Physicians | DED + 20% | DED + 40% |
| Other health care professionals licensed to perform such Services | DED + 20% | DED + 40% |
| Durable Medical Equipment, Prosthetics, and Orthotics | DED + 20% | DED + 40% |
| Convenient Care Centers | DED + 20% | DED + 40% |

Medical Pharmacy

| Benefit Description | In-Network | Out-of-Network |
|--|------------|----------------|
| Prescription Drugs administered in the office by: Family Physicians | DED + 20% | DED + 50% |
| Physicians other than Family Physicians and other health care professionals licensed to perform such Services | DED + 20% | DED + 50% |
| Out-of-Pocket Maximum per Person per Month (applies only after DED is satisfied) | \$200 | Not Applicable |
| <p>Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.</p> | | |

Preventive Health Services

| Benefit Description | In-Network | Out-of-Network |
|---|------------|----------------|
| Adult Wellness Services Rendered by Family Physicians | \$0 | 40% |
| Other health care professionals licensed to perform such Services | \$0 | 40% |
| All other locations | \$0 | 40% |
| Well Woman Services Rendered by Family Physicians | \$0 | 40% |
| Other health care professionals licensed to perform such Services | \$0 | 40% |
| All other locations | \$0 | 40% |
| Child Health Supervision Services Rendered by Family Physicians | \$0 | 40% |
| Other health care professionals licensed to perform such Service | \$0 | 40% |
| All other locations | \$0 | 40% |
| Mammograms | \$0 | \$0 |
| Routine Colonoscopies | \$0 | \$0 |

Outpatient Diagnostic Services

| Benefit Description | In-Network | Out-of-Network |
|--|---|----------------|
| Independent Clinical Lab | DED | DED + 40% |
| Independent Diagnostic Testing Facility 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 | See Hospital Services Outpatient | |

Emergency and Urgent Care Services

| Benefit Description | In-Network | Out-of-Network |
|------------------------------|--|----------------|
| Ambulance Services | In-Network DED + 20% | |
| Emergency Room Visits | See Hospital Services Emergency Room Visits | |
| Urgent Care Center | DED + 20% | DED + 20% |

Outpatient Surgical Services

| Benefit Description | In-Network | Out-of-Network |
|---|---|----------------------|
| Ambulatory Surgical Center Facility (per visit) | DED + 20% | DED + 40% |
| Radiologists, Anesthesiologists, and Pathologists | DED + 20% | In-Network DED + 20% |
| Other health care professional Services rendered by all other Providers | DED + 20% | DED + 40% |
| Outpatient Hospital Facility | See Hospital Services Outpatient | |

Hospital Services

| Benefit Description | In-Network | | Out-of-Network |
|---|------------|--|----------------------|
| | Option 1* | Option 2* and Out-of-State BlueCard® Participating | |
| Inpatient Facility Services (per admission) | DED + 20% | DED + 20% | **PAD + DED + 40% |
| Physician and other health care professional Services | DED + 20% | | In-Network DED + 20% |
| Outpatient Facility (per visit) | DED + 20% | DED + 25% | DED + 40% |
| Physician and other health care professional Services | DED + 20% | | In-Network DED + 20% |
| Therapy Services | DED + 20% | DED + 25% | DED + 40% |
| Emergency Room Visits Facility | DED + 20% | | DED + 20% |
| Physician and other health care professional Services | DED + 20% | | In-Network DED + 20% |

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and In-Network Coinsurance will apply to that admission.

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. This Plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) 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.

BlueScript® Pharmacy Program

All Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network DED**, which must be satisfied by you before any payment will be made by us. To verify if a Pharmacy is a Participating Pharmacy, you may access a current pharmacy directory, refer to our website at www.floridablue.com, or call the customer service phone number on your Benefit Booklet or Identification Card.

| Retail Pharmacy | *Participating Pharmacy | **Non-Participating Pharmacy |
|---|--------------------------------|---|
| Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply | DED + \$10 | DED + 50% of the Non-Participating Pharmacy Allowance |
| Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply | DED + \$30 | DED + 50% of the Non-Participating Pharmacy Allowance |
| Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply | DED + \$50 | DED + 50% of the Non-Participating Pharmacy Allowance |
| Mail Order Pharmacy | *Participating Pharmacy | **Non-Participating Pharmacy |
| Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a Three-Month Supply | DED + \$25 | DED + 50% of the Non-Participating Pharmacy Allowance |
| Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply | DED + \$75 | DED + 50% of the Non-Participating Pharmacy Allowance |
| Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply | DED + \$125 | DED + 50% of the Non-Participating Pharmacy Allowance |

| Specialty Pharmacy | *Participating Pharmacy | **Non-Participating Pharmacy |
|--|--------------------------------|--|
| <p>Preferred Generic Prescription Drugs and Covered OTC Drugs</p> <p>For up to a One-Month Supply</p> | <p>DED + \$10</p> | <p>DED + 50% of the Non-Participating Pharmacy Allowance</p> |
| <p>Preferred Brand Name Prescription Drugs or Supplies</p> <p>For up to a One-Month Supply</p> | <p>DED + \$30</p> | <p>DED + 50% of the Non-Participating Pharmacy Allowance</p> |
| <p>Non-Preferred Prescription Drugs or Supplies</p> <p>For up to a One-Month Supply</p> | <p>DED + \$50</p> | <p>DED + 50% of the Non-Participating Pharmacy Allowance</p> |

* Our payment for Covered Prescription Drugs is based on the **Participating Pharmacy Allowance**

** Our payment for Covered Prescription Drugs is based on the **Non-Participating Pharmacy Allowance** and may be less than the cost of the Drug or Supply. You are responsible for any charges in excess of the Non-Participating Pharmacy Allowance for purchases at Non-Participating Pharmacies.

Other Important information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:
 1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;
 2. Diaphragms indicated as covered in the Medication Guide; and
 3. Emergency contraceptives indicated as covered in the Medication Guide.
- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
 1. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
 2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.
- The Specialty Pharmacies designated, solely by us, are the only "Participating Pharmacy" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us in the Medication Guide as a Specialty Pharmacy is considered a Non-Participating Pharmacy for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty Drugs may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
- You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy.

This note does not apply to Specialty Drugs, which are covered only up to a One-Month Supply.
- Amounts incurred for Covered Prescription Drugs, Over-The-Counter Drugs and Covered Prescription Supplies will be applied to the In-Network Out-of-Pocket Maximum as indicated in this Schedule of Benefits.

Behavioral Health Services

| Benefit Description | In-Network | Out-of-Network |
|--|------------|----------------------|
| Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room | DED + 20% | In-Network DED + 20% |
| Hospital | DED + 20% | DED + 40% |
| Physician Services at Hospital and ER | DED + 20% | In-Network DED + 20% |
| Physician and other health care professionals licensed to perform such Services rendered at: Family Physician office | DED + 20% | DED + 40% |
| Specialist office | DED + 20% | DED + 40% |
| All other locations | DED + 20% | DED + 40% |
| Inpatient Facility Services Physicians and other health care professionals licensed to perform such Services | DED + 20% | In-Network DED + 20% |

Benefit Maximums

| | |
|--|----|
| Home Health Care Visits per Benefit Period..... | 20 |
| Inpatient Rehabilitation days per Benefit Period..... | 30 |
| Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... | 35 |
| Note: Refer to the Benefit Booklet for reimbursement guidelines. | |
| Skilled Nursing Facility Days per Benefit Period..... | 60 |

Additional Benefits/Features

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 BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.