BlueChoice

Schedule of Benefits - Plan 0702

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	$300	Combined with INN
Per Family per BP	$900	Combined with INN
Per Admission Deductible (PAD)	$0	$300
Emergency Room Per Visit Deductible (PVD)	$50	$50
Coinsurance		
(The percentage of the Allowed Amount **you pay** for Covered Services)	10%	30%
Out-of-Pocket Maximums - Embedded*		
Per Person per BP	$2,500	Combined with INN
Per Family per BP	$7,500	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.

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

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

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

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	$25 Copay	DED + 30%
Specialist Physicians and other health care professionals licensed to perform such Services	$50 Copay	DED + 30%
Allergy Injections rendered by		
Primary Care Physicians	$5 Copay	DED + 30%
Specialist Physicians and other health care professionals licensed to perform such Services	$5 Copay	DED + 30%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) **rendered by**		
Primary Care Physicians	$25 Copay	DED + 30%
Specialist Physicians and other health care professionals licensed to perform such Services	$50 Copay	DED + 30%
Outpatient Therapies and Spinal Manipulation rendered by		
Primary Care Physicians	$25 Copay	DED + 30%
Specialist Physicians and other health care professionals licensed to perform such Services	$50 Copay	DED + 30%

VIRTUAL HEALTH	YOU PAY
Virtual Visits	
General Medicine and Urgent Care rendered by a designated Virtual Care Provider	$25 Copay
Specialized Care rendered by a designated Virtual Care Provider	$50 Copay
Behavioral Health rendered by a designated Virtual Care Provider	$0 Copay

Please visit https://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Prescription Drugs administered in the office	20%	DED + 50%
Out-of-Pocket Maximum per person per month	$200	NA

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 and Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.

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PREVENTIVE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Adult Wellness Services rendered by		
Primary Care Physicians	$0 Copay	30%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	30%
All other locations	$0 Copay	30%
Adult Well Woman Services rendered by		
Primary Care Physicians	$0 Copay	30%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	30%
All other locations	$0 Copay	30%
Child Health Supervision Services rendered by		
Primary Care Physicians	$0 Copay	30%
Specialist Physicians and other health care professionals licensed to perform such Services	$0 Copay	30%
All other locations	$0 Copay	30%
Colonoscopies (Routine)	$0 Copay	30%
Mammograms	$0 Copay	$0 Copay

OUTPATIENT DIAGNOSTIC SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Independent Clinical Lab	10%	DED + 30%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$50 Copay	DED + 30%
All other diagnostic Services (e.g., X-rays)	$50 Copay	DED + 30%
Outpatient Hospital Facility	DED + 10%	DED + 30%

EMERGENCY AND URGENT CARE SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulance Services	10%	
Convenient Care Centers	$25 Copay	DED + 30%
Emergency Room Visits Facility	PVD + DED +10%	PVD + INN DED +10%
Physician Services	DED + 10%	INN DED + 10%
Urgent Care Center	$25 Copay	DED + $25 Copay

OUTPATIENT SURGICAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Ambulatory Surgical Center Facility (per visit)	DED + 10%	DED + 30%
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	INN DED + 10%
Other health care professional Services rendered by all other Providers	$50 Copay	DED + 30%
Outpatient Hospital Facility	DED + 10%	DED + 30%

HOSPITAL SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient		
Facility Services (per admission)	DED + 10%	*PAD + DED + 30%
Physician and other health care professional Services	DED + 10%	INN DED + 10%
Outpatient		
Facility (per visit)	DED + 10%	DED + 30%
Physician and other health care professional Services	DED + 10%	INN DED + 10%
Therapy Services	DED + 10%	DED + 30%
Emergency Room Visits		
Facility	PVD + DED +10%	PVD + INN DED +10%
Physician and other health care professional Services	DED + 10%	INN DED + 10%

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.

*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 In-Network Inpatient Cost Share will apply to that admission.

MENTAL HEALTH AND SUBSTANCE DEPENDENCY SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Inpatient Hospital, Psychiatric or Substance Abuse Facility Services	DED + 10%	*DED + 30%
Outpatient Facility Services rendered at		
Emergency Room	DED + 10%	INN DED + 10%
Hospital, Psychiatric or Substance Abuse Facility	DED + 10%	DED + 30%
Physician and other health care professionals licensed to perform such Services rendered at		
Primary Care Physician Office	$25 Copay	DED + 30%
Specialist Office	$50 Copay	DED + 30%
Emergency Room	DED + 10%	INN DED + 10%
Hospital, Psychiatric or Substance Abuse Facility	DED + 10%	INN DED + 10%
Primary Care Physician at all other locations	$25 Copay	DED + 30%
Specialist at all other locations	$50 Copay	DED + 30%

*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 In-Network inpatient Cost Share will apply to that admission.

OTHER SERVICES	IN-NETWORK (INN)	OUT-OF-NETWORK (OON)
Acupuncture	DED + 30%	DED + 30%
Birth Center	DED + 10%	DED + 30%
Dialysis Center	DED + 10%	DED + 30%
Durable Medical Equipment	DED + 10%	DED + 30%
Enteral Formula	DED + 10%	DED + 30%
Home Health Services	DED + 10%	DED + 30%
Hospice Services - Inpatient, Outpatient and Home	$0 Copay	DED + 30%
Outpatient Rehabilitation Facility	DED + 10%	DED + 30%
Prosthetic and Orthotic Devices	DED + 10%	DED + 30%
Skilled Nursing Facility	DED + 10%	DED + 30%

BENEFIT MAXIMUMS

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

Hearing Aids per Covered Plan Participant per BP $4,500

Note: External Hearing Aids are covered up to the benefit maximum within a 36 month period.

Home Health Care visits..... 30

Inpatient Rehabilitation (Combined In-Network and Out-of-Network) days per Covered Plan Participant per BP 21

Nutritional Evaluation/ Counseling Services visits 5

Outpatient Therapies and Spinal Manipulation visits (combined) 75

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 120

Substance Dependency Services per Covered Plan Participant ..... Unlimited

Sunrise Detox per day per diem $650

Beachcomber per Covered Plan Participant $12,900

Note: Covered services include inpatient, outpatient or any combination. The above listed treatment centers are limited to a 28 day maximum.

Waterproof Cast $300

Note: Deductible, Coinsurance, and Copayment do not apply.

Covid 19 Test Kits (OON-up to 8 tests per member, per month) $12

Benefit Maximum Carryover

If you or your Covered Dependent were covered under a prior group policy form issued to the Group by Florida Blue, Florida Blue HMO or Truli for Health and changed to this plan under the same Group, amounts applied to your Benefit Period maximums under the prior Florida Blue, Florida Blue HMO or Truli for Health policy will be applied toward your Benefit Period maximums under this plan.