

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

Financial Features		
<b>Deductible (DED)</b> <sup>1</sup> (PBP) <sup>2</sup> (DED is the amount the member is responsible for before Florida Blue HMO pays)	\$5,000 per person \$10,000 per family	NA per person NA per family
<b>Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$0	NA
<b>Coinsurance</b> (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	NA
<b>Out-of-Pocket Maximum (PBP)</b> (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$8,200 per person \$16,400 per family	NA per person NA per family
Office Services		
<b>Virtual Visits</b> <sup>3</sup> Primary Care Physician Specialist	\$0 Copay \$60 Copay	Not Covered Not Covered
<b>Physician Office Services</b> Value Choice Primary Care Physician <sup>4</sup> Value Choice Specialist <sup>4</sup> Primary Care Physician  Specialist	\$0 Copay \$20 Copay \$0 Copayment - Visits 1-3 PBP \$30 Copay for remaining Visits PBP \$60 Copay	Not Covered Not Covered Not Covered Not Covered
<b>Maternity</b> (Cost Share for initial visit only) Primary Care Physician Specialist	\$30 Copay \$60 Copay	Not Covered Not Covered
<b>Allergy Injections</b> (per visit) Primary Care Physician Specialist	\$30 Copay \$60 Copay	Not Covered Not Covered
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Medicine)	\$300 Copay	Not Covered
<b>Medical Pharmacy - Physician-Administered Medications</b> (applies to Office Setting and Specialty Pharmacy Vendors) <b>Monthly Out-of-Pocket (OOP) Maximum</b> <sup>5</sup> Preferred Non-Preferred <b>Provider</b> Preferred Non-Preferred	\$200 \$700  20% 20%	NA NA  Not Covered Not Covered
<b>Important Note:</b> Physician-Administered 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 benefit</i> . Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		

<sup>1</sup>DED = Deductible / <sup>2</sup>PBP = Per Benefit Period / <sup>3</sup>Virtual Visit services are only covered for In-Network providers. / <sup>4</sup>Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / <sup>5</sup>In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

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	In-Network	Out-of-Network
<b>Preventive Care</b>		
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b>	\$0 Copay	Not Covered
<b>Mammograms</b>	\$0 Copay	Not Covered
<b>Colonoscopy</b> (Routine for age 45+)	\$0 Copay	Not Covered
<b>Emergency Medical Care</b>		
<b>Urgent Care Centers</b> Value Choice Provider <sup>4</sup>	\$0 Copay - Visits 1-2 PBP \$100 Copay for Remaining Visits PBP \$100 Copay	Not Covered
All Other Providers		Not Covered
<b>Emergency Room</b> (per visit) (cost share waived if admitted) Facility Physician Services	\$350 Copay DED + 20%	\$350 Copay INN DED + 20%
<b>Ambulance Services</b>	DED + 20%	INN DED + 20%
<b>Outpatient Diagnostic Services</b>		
<b>Independent Diagnostic Testing Facility Services</b> (Includes Provider Services) Diagnostic Services (e.g., X-rays) Advanced Imaging Services (e.g., MRI, PET, CT)	\$60 Copay DED + 20%	Not Covered Not Covered
<b>Independent Clinical Lab</b> (e.g., Blood Work)	\$0 Copay	Not Covered
<b>Outpatient Hospital Facility</b>	DED + 20%	Not Covered
<b>Hospital / Surgical</b>		
<b>Ambulatory Surgical Center Facility</b> Facility (per visit) Provider Services	DED + 20% \$60 Copay	Not Covered Not Covered
<b>Outpatient Hospital Facility</b> (per visit) Therapy Services All other Services	DED + 20% DED + 20%	Not Covered Not Covered
<b>Inpatient Hospital and Rehabilitation Facility Services</b> (per admit)	DED + 20%	Not Covered
<b>Provider Services at Inpatient and Outpatient Facility</b> Radiologists, Anesthesiologists, and Pathologists All other Providers	DED + 20% DED + 20%	Not Covered Not Covered

<sup>4</sup>Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available.

Amount Member Pays

<b>Summary of Benefits for Covered Services</b>	In-Network	Out-of-Network
<b>Mental Health / Substance Dependency</b>		
<b>Virtual Visits<sup>3</sup></b>		
Primary Care Physician	\$0 Copay	Not Covered
Specialist	\$0 Copay	Not Covered
<b>Physician Office Services</b>		
Primary Care Physician	\$0 Copay	Not Covered
Specialist	\$0 Copay	Not Covered
<b>Emergency Room Facility Services</b> (per visit) (cost share waived if admitted)	\$0 Copay	\$0 Copay
<b>Outpatient Hospitalization Facility Services</b> (per visit)	\$0 Copay	Not Covered
<b>Inpatient Hospitalization Facility Services</b> (per admit)	\$0 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	\$60 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)	DED + 20%	Not Covered
<b>Durable Medical Equipment, Prosthetics and Orthotics</b>		
Motorized Wheelchair	\$500 Copay	Not Covered
All Other	\$0 Copay	Not Covered
<b>Home Health Care</b>	\$0 Copay	Not Covered
<b>Skilled Nursing Facility</b>	DED + 20%	Not Covered
<b>Hospice</b>	DED + 20%	Not Covered

<sup>3</sup>Virtual Visit services are only covered for In-Network providers.

**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>	35 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.

**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.