BlueOptions

Florida Blue

For Small Groups
All Copay Health Benefit Plan 14003

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$500 per person $1,500 per family	$1,000 per person $3,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	50% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$2,000 per person $6,000 per family	$5,000 per person $10,000 per family
Office Services		
Physician Office Services		
Blue Physician Recognition	$10 Copay	50% after Deductible
Primary Care Physician	$10 Copay	50% after Deductible
Specialist	$25 Copay	50% after Deductible
e-Office Visit	$10 Copay	50% after Deductible
The Blue Physician Recognition (BPR) designation means the physician has demonstrated a commitment to delivering quality and patient-centered care by participating in one of the following Florida Blue programs: Patient Centered Medical Home (PCMH), Comprehensive Primary Care (CP2) or an Accountable Care arrangement. The BPR designation does not serve as a measure of the quality of care provided by a physician or whether the physician will meet your particular healthcare needs. Absence of a BPR icon does not mean the physician is of low quality. It simply means that the physician does not participate in one of these programs.		
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$10 Copay	50% after Deductible
Specialist	$25 Copay	50% after Deductible
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	50% after Deductible
Specialist	$10 Copay	50% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$75 Copay	50% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)		
In-Network Monthly Out-of-Pocket (OOP) Maximum[3]	$200	
Provider	20%	50% after Deductible
Physician-Administered Medications – These 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 *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	50%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	$0
Emergency Medical Care		
Urgent Care Centers	$30 Copay	50% after Deductible
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$100 Copay	$100 Copay

[1] DED = Deductible

[2] PBP = Per Benefit Period

[3] In-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.

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Emergency Medical Care (continued)		
Ambulance Services	20% after Deductible	20% after In-Network Deductible
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 Med.)	 $35 Copay $75 Copay	 50% after Deductible 50% after Deductible
Independent Clinical Lab (e.g., Blood Work)	$0	50% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 Option 2	 $150 Copay $350 Copay	 50% after Deductible 50% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	50% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services Option 1 Option 2 All other Services Option 1 Option 2	 $35 Copay $40 Copay $150 Copay $350 Copay	 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 Option 2	 $200 Copay per day ($600 max) $300 Copay per day ($900 max)	 50% after Deductible 50% after Deductible
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit) Option 1 and Option 2	 $0	 50% after Deductible
Outpatient Hospitalization Facility Service (per visit) Option 1 and Option 2	 $0	 50% after Deductible
Emergency Room Facility Services (per visit)	$0	$0
Provider Services at Hospital and ER Primary Care Physician / Specialist	 $0	 $0
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	 $0	 50% after Deductible
Outpatient Office Visit Primary Care Physician / Specialist	 $0	 50% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	$0	$0
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	$0	$0
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 $10 Copay $25 Copay	 50% after Deductible 50% after Deductible

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Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$25 Copay	50% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	$35 Copay	50% after Deductible
Option 2	$40 Copay	50% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	50% after Deductible
Home Health Care	20% after Deductible	50% after Deductible
Skilled Nursing Facility	20% after Deductible	50% after Deductible
Hospice	20% after Deductible	50% after Deductible

Important: There are certain medical services **for which members are required to obtain a prior authorization** on before receiving that service. If they don't, they will have to **pay the entire cost** of the service. Ensure they know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Summary of Benefits for Covered Services	Amount Member Pays - Exclusive Pharmacy	
Prescription Drug Program (BlueScript®)		
Exclusive Provider Services: An Exclusive Provider pharmacy must be used when a member needs to have a prescription filled or the member will have to pay the full cost of the drug (except in certain situations such as emergencies). Inform members to log into their member account at floridablue.com and click **Find a Doctor and More** to locate an Exclusive Provider pharmacy.		
	Retail Pharmacy (1 month supply)	**Mail Order** (3 month supply)
Generic Drugs – Tier 1		
Preventive (e.g., oral contraceptives)	$0	$0
Condition Care Rx (high blood pressure, cholesterol, diabetes, depression, asthma)	$4 Copay	$8 Copay
All other Generics	$10 Copay	$20 Copay
Brand Drugs – Tier 2		
Condition Care Rx (high blood pressure, cholesterol, diabetes, depression, asthma)	$15 Copay	$30 Copay
All other Preferred Brand Drugs	$30 Copay	$60 Copay
Non-preferred Brand Drugs – Tier 3		
Non-preferred Brand Drugs	$50 Copay	$100 Copay
Specialty Drugs		
Specialty Drugs purchased from a Specialty Pharmacy	$150 Copay	Not Covered
Inform the member that if a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the member will be responsible for: 1) the Copayment applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueOptions Pharmacy Program Schedule of Benefits. **BlueScript Pharmacy benefit also provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost. Additionally, certain vaccines which are covered under the Wellness Benefits can be administered by Pharmacists who are certified.**		

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Summary of Benefits for Covered Services	Amount Member Pays - Exclusive Provider
Pediatric Vision (under age 19)	
Exclusive Provider Services: The services listed below must be received from an Exclusive Provider or the member will have to pay the full cost of the service (except in certain situations such as emergencies). Inform members to log onto floridablue.com and click **Find a Doctor and More** to locate an Exclusive Provider near them. For vision care they select the "routine vision" option and for dental care they select the "dentist" option.	
Exam	$0
Eyeglass Lenses	$0
Frames	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 20% discount (No discount at Sam's/Walmart)
Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 15% discount (No discount at Sam's/Walmart)
Note: Anything over the allowance will not go toward your out-of-pocket maximum.	
Pediatric Dental (under age 19)	
Preventive, basic and major	$0

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days 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

- Encourage our members to call the care consultants team at 1-888-476-2227 to find out more about their benefits and/or treatment options. This can help them save time and money.
- Let our members know that there is online access to about everything on their health benefit plan as well as all of our self-service tools.

This is not an insurance contract or Benefit Booklet. 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 BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.