BlueCare

Stetson University
HSA Compatible Health Plan 128

Florida Blue Your Health Solutions Partner | HMO

Summary of Benefits for Covered Services

Important things to keep in mind when reviewing this Summary of Benefits

- This Summary of Benefits is only a partial description of the many benefits and services provided or authorized by Florida Blue HMO and is not considered 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.
- For the lowest out-of-pocket costs, choose doctors, hospitals, pharmacies, and other health care providers who are considered in-network. To find in-network providers, visit our online provider directory at FloridaBlue.com and select the plan name.
- The amount a member pays for covered services add up and count toward deductibles, out-of-pocket maximums, and any listed benefit maximums per person per benefit period (PBP).

Financial Features	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Deductible (DED) Shared (DED is the amount the member must pay before Florida Blue HMO pays) Individual Family	 $2,700 Not Applicable	 Not Applicable Not Applicable
Coinsurance (Coinsurance is the percentage of the costs of a covered health care service a member pays, typically after the deductible is paid.)	20%	Not Applicable
Out-of-Pocket Maximum Shared (Out-of-pocket maximum includes DED, coinsurance, copayments and prescription drugs) Individual Family	 $8,000 Not Applicable	 Not Applicable Not Applicable

Important information about Deductibles and Out-of-Pocket Maximums

Deductible

- **Embedded** - If more than one person is covered under the plan, each person only has to meet the individual deductible, and not the entire family deductible before Florida Blue HMO will begin to pay for covered services for that person.
- **Shared -** The entire family deductible is shared with all members on the plan. Florida Blue HMO will begin to pay for covered services after the total family amount is met. One person or a combination of family members can contribute to the total deductible amount.

Out-of-Pocket Maximum

- **Embedded** - Once an individual with family coverage meets the individual out-of-pocket maximum, the plan will pay 100% of all covered services for the rest of the benefit period for that person.
- **Shared** - The entire family out-of-pocket maximum amount is shared with all members on the plan. Any one person or a combination of family members can meet the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, the plan will pay 100% of all covered services for all covered members for the rest of the benefit period.

Note: If there is only one person on a plan and a family deductible and out-of-pocket are listed, only the individual amounts apply.

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Virtual Health Services	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Virtual Office Visits		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Behavioral Health (Mental Health/Substance Abuse)		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Telemedicine Services via Teladoc (General Medicine/Behavioral Health/Dermatology)	$10 Copay	Not Covered
Office Services	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Physician Office Services		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Maternity		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Allergy Injections (per visit)		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 20%	Not Covered
Medical Pharmacy administered in a Physician's Office	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Medication	DED + 20%	Not Covered
Monthly Out-of-Pocket (OOP) Maximum	$200/Calendar Month	Not Applicable

Important Notes:

- The cost share for medical pharmacy services applies to the prescription drug only and is separate from the office visit cost share. Immunizations, allergy injections, and services covered through a pharmacy program are not considered medical pharmacy. A list of the physician-administered medications is included in the medication guide.
- In-network medical pharmacy will be paid at 100% for the remainder of the calendar month once monthly out-of-pocket maximum amount is met.

Preventive Care	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Adult Wellness Services		
Primary Care Provider	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Mammograms	$0 Copay	Not Covered
Routine Colonoscopy	$0 Copay	Not Covered
Child Wellness Services		
Primary Care Provider	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered

Emergency Medical Care	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Urgent Care Centers	DED + 20%	Not Covered
Emergency Room		
Facility	DED + 20%	INN DED + 20%
Physician Services	DED + 20%	INN DED + 20%
Ambulance Services	DED + 20%	INN DED + 20%

Outpatient Diagnostic Services	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Independent Clinical Lab (e.g., Blood Work)	DED + 20%	Not Covered
Independent Diagnostic Testing Center (Includes provider services)		
Diagnostic Services (e.g., x-rays)	DED + 20%	Not Covered
Advanced Imaging Services (e.g., MRI, PET, CT)	DED + 20%	Not Covered
Outpatient Hospital Facility	DED + 20%	Not Covered

Hospital / Surgical	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Inpatient Services		
Facility	DED + 20%	Not Covered
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	Not Covered
All other Providers	DED + 20%	Not Covered
Outpatient Services		
Ambulatory Surgical Center		
Facility	DED + 20%	Not Covered
Provider Services	DED + 20%	Not Covered
Hospital		
Facility	DED + 20%	Not Covered
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	Not Covered
All other Providers	DED + 20%	Not Covered

Behavioral Health (Mental Health / Substance Dependency)	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Physician Office Services		
Primary Care Provider	DED + 20%	Not Covered
Specialist	DED + 20%	Not Covered
Emergency Room		
Facility	DED + 20%	INN DED + 20%
Physician services	DED + 20%	INN DED + 20%
Inpatient Hospital Services		
Facility	DED + 20%	Not Covered
Physician services	DED + 20%	Not Covered
Outpatient Hospital Services		
Facility	DED + 20%	Not Covered
Physician services	DED + 20%	Not Covered

Other Services	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Durable Medical Equipment		
Motorized Wheelchairs	DED + 20%	Not Covered
All other	DED + 20%	Not Covered
Home Health Care	DED + 20%	Not Covered
Hospice	DED + 20%	Not Covered
Outpatient Therapy (per visit)		
Outpatient Rehabilitation Facility	DED + 20%	Not Covered
Outpatient Hospital Facility	DED + 20%	Not Covered
Prosthetic and Orthotics	DED + 20%	Not Covered
Skilled Nursing Facility	DED + 20%	Not Covered

Benefit Maximums	
Home Health Care	60 Visits
Inpatient Rehabilitation Therapy	30 Days
Outpatient Therapy	35 Visits
Skilled Nursing Facility	60 Days
Spinal Manipulations	26 (accumulates towards the Outpatient Therapy maximum)