

**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
<b>Deductible (DED) Shared</b> (DED is the amount the member must pay before Florida Blue HMO pays) Individual Family	 \$6,500 \$6,500	 Not Applicable Not Applicable
<b>Coinsurance</b> (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
<b>Out-of-Pocket Maximum Embedded</b> (Out-of-pocket maximum includes DED, coinsurance, copayments and prescription drugs) Individual Family	 \$16,000 \$16,000	 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.

<b>Virtual Health Services</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Virtual Office Visits</b>			
Primary Care Provider	DED + 20%	Not Covered	
Specialist	DED + 20%	Not Covered	
<b>Behavioral Health (Mental Health/Substance Abuse)</b>			
Primary Care Provider	DED + 20%	Not Covered	
Specialist	DED + 20%	Not Covered	
<b>Telemedicine Services via Teladoc (General Medicine/Behavioral Health/Dermatology)</b>	\$10 Copay	Not Covered	
<b>Office Services</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Physician Office Services</b>			
Primary Care Provider	DED + 20%	Not Covered	
Specialist	DED + 20%	Not Covered	
<b>Maternity</b>			
Primary Care Provider	DED + 20%	Not Covered	
Specialist	DED + 20%	Not Covered	
<b>Allergy Injections (per visit)</b>			
Primary Care Provider	DED + 20%	Not Covered	
Specialist	DED + 20%	Not Covered	
<b>Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)</b>	DED + 20%	Not Covered	
<b>Medical Pharmacy administered in a Physician's Office</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Medication</b>			
	DED + 20%	Not Covered	
<b>Monthly Out-of-Pocket (OOP) Maximum</b>	\$200/Calendar Month	Not Applicable	
<b>Important Notes:</b>			
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>			

<b>Preventive Care</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Adult Wellness Services</b>			
Primary Care Provider	\$0 Copay	Not Covered	
Specialist	\$0 Copay	Not Covered	
Mammograms	\$0 Copay	Not Covered	
Routine Colonoscopy	\$0 Copay	Not Covered	
<b>Child Wellness Services</b>			
Primary Care Provider	\$0 Copay	Not Covered	
Specialist	\$0 Copay	Not Covered	
<b>Emergency Medical Care</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Urgent Care Centers</b>	DED + 20%	Not Covered	
<b>Emergency Room</b>			
Facility	DED + 20%	INN DED + 20%	
Physician Services	DED + 20%	INN DED + 20%	
<b>Ambulance Services</b>	DED + 20%	INN DED + 20%	
<b>Outpatient Diagnostic Services</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Independent Clinical Lab</b> (e.g., Blood Work)	DED + 20%	Not Covered	
<b>Independent Diagnostic Testing Center</b> (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	
<b>Outpatient Hospital Facility</b>	DED + 20%	Not Covered	
<b>Hospital / Surgical</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>	
<b>Inpatient Services</b>			
Facility	DED + 20%	Not Covered	
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	Not Covered	
All other Providers	DED + 20%	Not Covered	
<b>Outpatient Services</b>			
<b>Ambulatory Surgical Center</b>			
Facility	DED + 20%	Not Covered	
Provider Services	DED + 20%	Not Covered	
<b>Hospital</b>			
Facility	DED + 20%	Not Covered	
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	Not Covered	
All other Providers	DED + 20%	Not Covered	

<b>Behavioral Health (Mental Health / Substance Dependency)</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Physician Office Services</b>			
Primary Care Provider		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
<b>Emergency Room</b>			
Facility		DED + 20%	INN DED + 20%
Physician services		DED + 20%	INN DED + 20%
<b>Inpatient Hospital Services</b>			
Facility		DED + 20%	Not Covered
Physician services		DED + 20%	Not Covered
<b>Outpatient Hospital Services</b>			
Facility		DED + 20%	Not Covered
Physician services		DED + 20%	Not Covered
<b>Other Services</b>		<b>Amount Member Pays</b>	
<b>Benefit Description</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Durable Medical Equipment</b>			
Motorized Wheelchairs		DED + 20%	Not Covered
All other		DED + 20%	Not Covered
<b>Home Health Care</b>		DED + 20%	Not Covered
<b>Hospice</b>		DED + 20%	Not Covered
<b>Outpatient Therapy (per visit)</b>			
Outpatient Rehabilitation Facility		DED + 20%	Not Covered
Outpatient Hospital Facility		DED + 20%	Not Covered
<b>Prosthetic and Orthotics</b>		DED + 20%	Not Covered
<b>Skilled Nursing Facility</b>		DED + 20%	Not Covered
<b>Benefit Maximums</b>			
<b>Home Health Care</b>	60 Visits		
<b>Inpatient Rehabilitation Therapy</b>	30 Days		
<b>Outpatient Therapy</b>	35 Visits		
<b>Skilled Nursing Facility</b>	60 Days		
<b>Spinal Manipulations</b>	26 (accumulates towards the Outpatient Therapy maximum)		