

### 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 and is not considered 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.
- 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	
	In-Network	Out-of-Network
<b>Deductible (DED) Embedded</b> (DED is the amount the member must pay before Florida Blue pays)		
Individual	\$2,500	\$5,000
Family	\$6,250	\$11,250
<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%	30%
<b>Out-of-Pocket Maximum Embedded</b> (Out-of-pocket maximum includes DED, coinsurance, copayments and prescription drugs)		
Individual	\$8,000	\$16,000
Family	\$12,000	\$24,000

#### 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 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 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	\$25 Copay	Not Covered
Specialist	\$50 Copay	Not Covered
<b>Behavioral Health (Mental Health/Substance Abuse)</b>		
Primary Care Provider	\$20 Copay	Not Covered
Specialist	\$20 Copay	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	\$25 Copay	DED + 30%
Specialist	\$50 Copay	DED + 30%
<b>Maternity</b>		
Primary Care Provider	\$25 Copay	DED + 30%
Specialist	\$50 Copay	DED + 30%
<b>Allergy Injections (per visit)</b>		
Primary Care Provider	\$10 Copay	DED + 30%
Specialist	\$10 Copay	DED + 30%
<b>Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)</b>	\$500 Copay	DED + 30%
<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>	20%	DED + 30%
<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	DED + 30%	
Specialist	\$0 Copay	DED + 30%	
Mammograms	\$0 Copay	DED + 30%	
Routine Colonoscopy	\$0 Copay	DED + 30%	
<b>Child Wellness Services</b>			
Primary Care Provider	\$0 Copay	DED + 30%	
Specialist	\$0 Copay	DED + 30%	
<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>	\$75 Copay	DED + \$75 Copay	
<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)	\$100 Copay	DED + 30%	
<b>Independent Diagnostic Testing Center</b> (Includes provider services)			
Diagnostic Services (e.g., x-rays)	\$100 Copay	DED + 30%	
Advanced Imaging Services (e.g., MRI, PET, CT)	\$500 Copay	DED + 30%	
<b>Outpatient Hospital Facility</b>	\$500 Copay	DED + 30%	
<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%	DED + 30%	
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	INN DED + 20%	
All other Providers	DED + 20%	INN DED + 20%	
<b>Outpatient Services</b>			
<b>Ambulatory Surgical Center</b>			
Facility	\$500 Copay	DED + 30%	
Provider Services	\$50 Copay	DED + 30%	
<b>Hospital</b>			
Facility	DED + 20%	DED + 30%	
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	INN DED + 20%	
All other Providers	DED + 20%	INN DED + 20%	

<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	\$20 Copay	DED + 30%	
Specialist	\$20 Copay	DED + 30%	
<b>Emergency Room</b>			
Facility	DED + 20%	DED + 20%	
Physician services	INN DED + 20%	INN DED + 20%	
<b>Inpatient Hospital Services</b>			
Facility	DED + 20%	DED + 30%	
Physician services	DED + 20%	DED + 30%	
<b>Outpatient Hospital Services</b>			
Facility	DED + 20%	DED + 30%	
Physician services	DED + 20%	DED + 30%	
<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%	DED + 30%	
All other	DED + 20%	DED + 30%	
<b>Home Health Care</b>	DED + 20%	DED + 30%	
<b>Hospice</b>	DED + 20%	DED + 30%	
<b>Outpatient Therapy (per visit)</b>			
Outpatient Rehabilitation Facility	\$50 Copay	DED + 30%	
Outpatient Hospital Facility	\$50 Copay	DED + 30%	
<b>Prosthetic and Orthotics</b>	DED + 20%	DED + 30%	
<b>Skilled Nursing Facility</b>	DED + 20%	DED + 30%	
<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)		

**Prescription Drug Program**

If your employer purchased prescription drug coverage from Florida Blue, a separate pharmacy benefit summary will be provided that includes an overview and prescription costs.

Important Note: Your health plan may include prescription drug coverage that only provides coverage at exclusive pharmacies, except for emergency situations.