

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Financial Features		
Deductible (DED is the amount the member is responsible for before Florida Blue pays)	\$500 per person \$1,500 per family	Combined with In-Network
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$1,500 per person \$4,500 per family	Combined with In-Network
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care Teladoc	\$15 Copay \$15 Copay \$15 Copay \$15 Copay	40% after Deductible 40% after Deductible 40% after Deductible N/A
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	\$15 Copay \$15 Copay	40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	\$5 Copay \$5 Copay	40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$15 Copay	40% after Deductible
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	\$0	40%
Mammograms	\$0	\$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	\$0	40%
Emergency Medical Care		
Urgent Care Centers	\$15 Copay	\$15 Copay
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible
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)	\$15 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$15 Copay	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	20%	40%
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	20% after Deductible	40% after Deductible



BlueChoice
 For Public Risk Management Groups
 2019_2020 Plan 0727



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Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)	20% after Deductible	\$300 PAD, then 40% after Deductible
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	20% after Deductible	\$300 PAD, then 40% after Deductible
Outpatient Hospitalization Facility Service (per visit)	20% after Deductible	40% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible
Provider Services at Hospital Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Provider Services at ER Primary Care Physician / Specialist	20% after Deductible	20% after Deductible
Provider Services at locations other than Office, Hospital and ER Primary Care Physician / Specialist	\$0	40% after Deductible
Outpatient Office Visit Primary Care Physician / Specialist	\$15 Copay	40% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	40% after Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible
Home Health Care	20% after Deductible	40% after Deductible
Skilled Nursing Facility	20% after Deductible	40% after Deductible



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Other Special Services (continued)		
Hospice	20% after Deductible	40% after Deductible

Benefit Maximums	
Home Health Care	20 Visits PBP
Outpatient Therapy	54 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
Retail (30 days) (generic/preferred brand/non-preferred brand)	\$5/\$35/\$35	50% of allowance
Mail Order (90 days) (generic/preferred brand/non-preferred brand)	\$10/\$70/\$70	50% of allowance

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers

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.
- Go to 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.

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

