

Amount Member Pays

In-Network                      Out-of-Network

**Summary of Benefits for Covered Services**

<b>Financial Features</b>		
<b>Deductible</b> (DED is the amount the member is responsible for before Florida Blue HMO pays)	\$0	Not covered
<b>Coinsurance</b> (Coinsurance is the percentage the member pays for services)	0%	Not covered
<b>Out-of-Pocket Maximum (PBP)</b> (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$1,500 per person \$3,000 per family	Not covered
<b>Office Services</b>		
<b>Physician Office Services</b>		
Primary Care Physician	\$15 Copay	Not covered
Specialist	\$35 Copay	Not covered
Convenient Care	\$15 Copay	Not covered
Teladoc	\$15 Copay	N/A
<b>Maternity</b> (Cost Share for initial visit only)		
Primary Care Physician	\$15 Copay	Not covered
Specialist	\$35 Copay	Not covered
<b>Allergy Injections</b> (per visit)		
Primary Care Physician	\$10 Copay	Not covered
Specialist	\$10 Copay	Not covered
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Med.)	\$0	Not covered
<b>Preventive Care</b>		
<b>Routine Adult &amp; Child Preventive Services, Wellness Services, and Immunizations</b>	\$0	Not covered
<b>Mammograms</b>	\$0	Not covered
<b>Colonoscopy</b> (Routine for age 50+ then frequency schedule applies)	\$0	Not covered
<b>Emergency Medical Care</b>		
<b>Urgent Care Centers</b>	\$35 Copay	\$35 Copay
<b>Emergency Room Facility Services</b> (per visit) (copayment waived if admitted)	\$50 Copay	\$50 Copay
<b>Ambulance Services</b>	\$0	\$0
<b>Outpatient Diagnostic Services</b>		
<b>Independent Diagnostic Testing Facility Services</b> (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	\$0	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	\$0	Not covered
<b>Independent Clinical Lab</b> (e.g., Blood Work)	\$0	Not covered
<b>Outpatient Hospital Facility Services</b> (per visit) (e.g., Blood Work and X-rays)	\$200 Copay	Not covered



**BlueCare**  
For Public Risk Management Groups  
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<b>Hospital / Surgical</b>		
<b>Ambulatory Surgical Center Facility (ASC)</b>	\$200 Copay	Not covered
<b>Outpatient Hospital Facility Services</b> (per visit) Therapy Services All other Services	\$5 Copay \$200 Copay	Not covered Not covered
<b>Inpatient Hospital Facility and Rehabilitation Services</b> (per admit)	\$150 per day up to \$750	Not covered
<b>Mental Health / Substance Dependency</b>		
<b>Inpatient Hospitalization Facility Services</b> (per admit)	\$150 per day up to \$750	Not covered
<b>Outpatient Hospitalization Facility Service</b> (per visit)	\$200	Not covered
<b>Emergency Room Facility Services</b> (per visit)	\$50	\$50
<b>Provider Services at Hospital</b> Primary Care Physician / Specialist	\$0	Not covered
<b>Provider Services at ER</b> Primary Care Physician / Specialist	\$0	\$0
<b>Provider Services at Locations other than Office, Hospital and ER</b> Primary Care Physician / Specialist	\$0	Not covered
<b>Outpatient Office Visit</b> Primary Care Physician / Specialist	\$15 Copay/ \$35 Copay	Not covered
<b>Other Provider Services</b>		
<b>Provider Services at Hospital</b>	\$0	Not covered
<b>Provider Services at ER</b>	\$0	\$0
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)</b>	\$0	Not covered
<b>Provider Services at Locations other than Office, Hospital and ER</b> Primary Care Physician Specialist	\$0 \$0	Not covered Not covered
<b>Other Special Services</b>		
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations</b> Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	\$35 Copay \$5 Copay	Not covered Not covered
<b>Durable Medical Equipment, Prosthetics and Orthotics</b> Motorized Wheelchair All Other	\$0 \$0	Not covered Not covered
<b>Home Health Care</b>	\$0	Not covered



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<b>Other Special Services (continued)</b>		
Skilled Nursing Facility	\$0	Not covered
Hospice	\$0	Not covered

**Preauthorization for select services:** Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit [floridablue.com/Authorization](http://floridablue.com/Authorization) or call the toll-free number on their member ID card to see if a prior authorization is required.

Benefit Maximums	
Home Health Care	No Maximum
Inpatient Rehabilitation Therapy	No Maximum
Outpatient Therapy	62 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	90 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
<b>Retail (30 days)</b> (generic/preferred brand/non-preferred brand)	\$10/\$25/\$60	Not Covered
<b>Mail Order (90 days)</b> (generic/preferred brand/non-preferred brand)	\$20/\$50/\$120	Not Covered

**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](http://floridablue.com).
- Go to [floridablue.com](http://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.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute 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.

