



# BlueOptions

For Individuals Under 65

## Benefit Summary for Health Plan 570 – Hospital and Surgical Coverage

### Understanding Your Share for Covered Services

This health insurance policy<sup>1</sup> is ideal for a covered hospital admission and the associated physician office services and covered outpatient surgeries as an outpatient of a hospital, ambulatory surgical center, or a physicians' office (i.e. bone setting, casting and/or stitching). Plus, you can relax knowing you still have coverage for trips to the emergency room (ER) even if you aren't admitted and no surgical services are preformed.

NetworkBlue<sup>2</sup> is the Preferred Provider Network designated as "In-Network" for BlueOptions.

#### Benefits for Covered Services

#### Amount Member Pays

Benefits for Covered Services	Amount Member Pays
<b>Office Services</b>	
<b>Physician Office Services</b> (Coverage for Surgical Services only) In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit Physician Office Services Associated with a Covered Surgery are Covered when rendered in the Physician's Office, at an Ambulatory Care Center, Inpatient Hospital, Outpatient Hospital, or Emergency Room.	CYD <sup>3</sup> + 20% Coinsurance <sup>4</sup> CYD + 20% Coinsurance CYD + 40% Coinsurance \$10 Copayment CYD + 40% Coinsurance
<b>Advanced Imaging Services (AIS)</b> (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network AIS are Covered when proximately related to a Covered Surgery.	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Allergy Injections</b> (per visit)	Not Covered
<b>Medical Pharmacy</b> (Applies to Office Setting and Specialty Pharmacy Vendors) In-Network Provider (\$200 Monthly Out-of-Pocket Maximum <sup>5</sup> per Member) Out-of-Network	(Proximately Related to Surgical Services) 20% Coinsurance CYD + 50% Coinsurance
<b>Preventive Care</b>	
<b>Adult Wellness Benefit Maximum</b>	Not Covered
<b>Routine Adult Physical Exam and Immunizations</b>	Not Covered
<b>Well Woman Exam</b> (e.g., Annual GYN)	Not Covered
<b>Mammograms</b> (Covered at 100% of Allowed Amount, In- and Out-of-Network)	\$0
<b>Well Child</b> (No PCY <sup>6</sup> max) In-Network Family Physician In-Network Specialist Out-of-Network	20% Coinsurance 20% Coinsurance 40% Coinsurance
<b>Prescription Drug Program (BlueScript)®</b>	
<b>Pharmacy Deductible (PD)</b>	\$0
<b>Generic, Preferred Brand Name and Non-Preferred Prescription Drugs</b>	Access to Discounts
The BlueRx Discounts Program is offered with this BlueOptions health plan and is designed to give you special discounted pricing on Generic Prescription Drug, Brand Name Prescription Drug and Non-preferred Prescription Drug purchases when you show your ID card at participating pharmacies. You'll also be able to receive savings on Prescription Drugs ordered through the mail by purchasing them through PrimeMail ®. The BlueRx Discounts program is administered by Prime Therapeutics LLC ® and is not an insurance product or part of the BlueOptions insurance policy. Participating Pharmacies are independently contracted and only Participating Pharmacies offer these program discounts.	

1 Policies have limitations and exclusions and are medically underwritten.

2 Network Blue is one of our Preferred Provider Networks made up of independent hospitals, physicians and ancillary providers.

3 CYD = Calendar Year Deductible

4 Coinsurance is the percentage the member pays for service.

5 In-Network Medical Pharmacy will be paid at 100% for remainder of calendar month once Out-of-Pocket Maximum is met.

6 PCY = Per Calendar Year

Note: Out-of-Network services may be subject to balance billing.

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Benefits for Covered Services	Amount Member Pays
<b>Emergency Medical Care</b>	
<b>Urgent Care Centers</b> (Surgical Services Only) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>7</sup></b> (per visit) If Admitted or if a Surgical Service is performed In-Network Out-of-Network Non-Surgical Services/Not Admitted Per Visit Deductible (PVD) <sup>9</sup> In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance \$2,500 PVD + CYD + 20% Coinsurance PVD + CYD + 40% Coinsurance
<b>Ambulance Services</b> (Ground travel / air and water travel, per day maximum) In-Network / Out-of-Network	\$5,000 In-Network CYD + 20% Coinsurance
<b>Outpatient Diagnostic Services</b>	
<b>Independent Diagnostic Testing Facility Services<sup>8</sup></b> (e.g., X-rays) – Per Visit (Includes Provider Services) In-Network Diagnostic Services (Except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Out-of-Network Diagnostic Tests and X-rays are Covered when proximately related to a Covered Surgery.	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Independent Clinical Lab<sup>8</sup></b> (e.g., blood work) In-Network / Out-of-Network Lab Services are Covered when proximately related to a Covered Surgery.	CYD + 20% Coinsurance / CYD + 40% Coinsurance
<b>Outpatient Hospital Facility Services<sup>7</sup></b> (per visit) (Surgical Services Only) (e.g. Surgeries, proximately related blood work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Mental Health/Substance Dependency</b>	
<b>Mental Health</b>	Not Covered
<b>Substance Dependency</b>	Not Covered

7 Includes services rendered at a Hospital, Psychiatric Facility or Substance Abuse Facility. Please refer to the Provider Directory to determine the applicable option for each In-Network Hospital. Services rendered at an Out-of-State BlueCard<sup>®</sup> Program participating hospital are at the Option 2 In-Network cost sharing amount.

8 Includes services rendered at locations other than Hospital, Psychiatric Facility, Substance Abuse Facility or a Physician's Office.

9 The Emergency Room Non-Surgical Per Visit Deductible (PVD) must be satisfied for Emergency Room Facility/Physician and other health care professional services when there is no resulting admission or Surgical Services performed. Only one PVD applies per Emergency Room visit.

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Benefits for Covered Services	Amount Member Pays
<b>Other Provider Services</b>	
<b>Provider Services at Hospital and ER<sup>7</sup></b> If admitted or if a Surgical Service is performed In-Network / Out-of-Network Non-Surgical Services Per Visit Deductible (PVD) In-Network Out-of-Network	In-Network CYD + 20% Coinsurance  \$2,500 PVD + CYD + 20% Coinsurance PVD + CYD + 40% Coinsurance
<b>Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center</b> In-Network / Out-of-Network Covered when proximately related to a Covered Surgery.	In-Network CYD + 20% Coinsurance
<b>Provider Services at Locations other than Office, Hospital and ER<sup>8</sup></b> (Surgical Services Only) In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Other Special Services</b>	
<b>Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations</b>	Not Covered
<b>Durable Medical Equipment, Prosthetics and Orthotics<sup>7</sup></b> (If provided during Surgery or at a time of discharge) In-Network / Out-of-Network	CYD + 20% Coinsurance / CYD + 40% Coinsurance
<b>Home Health Care</b>	Not Covered
<b>Skilled Nursing Facility</b>	Not Covered
<b>Hospice (Lifetime max)</b> In-Network / Out-of Network	No Maximum CYD + 20% Coinsurance / CYD + 40% Coinsurance
<b>Hospital/Surgical</b>	
<b>Ambulatory Surgical Center Facility (ASC)<sup>8</sup></b> (Surgical Services Only) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Provider Services Rendered at an ASC<sup>8</sup></b> (Surgical Services Only) In-Network Family Physician In-Network Specialist Out-of-Network	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Inpatient Hospital Facility and Rehabilitation Services<sup>7</sup></b> (per admit) In-Network (Option 1 / Option 2) Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation limit PCY - 21 days CYD + 20% Coinsurance \$500 PAD + CYD + 40% Coinsurance
<b>Outpatient Hospital Facility Services<sup>8</sup></b> (per visit) (Surgical Services Only) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All Other Services (Option 1 / Option 2) Out-of-Network Facility	CYD + 20% Coinsurance CYD + 20% Coinsurance CYD + 40% Coinsurance
<b>Emergency Room Facility Services (ER)<sup>7</sup></b> (per visit) If Admitted or if a surgical service is performed In-Network Out-of-Network Non-Surgical Services Per Visit Deductible (PVD) In-Network Out-of-Network	CYD + 20% Coinsurance CYD + 40% Coinsurance  \$2,500 PVD + CYD + 20% Coinsurance PVD + CYD + 40% Coinsurance

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<b>Financial Features</b>	
<b>Calendar Year Deductible (CYD)</b> (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	\$250 / N/A \$750 / N/A
<b>Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)</b>	\$500
<b>Coinsurance</b> In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	20% / 40%
<b>Out-of-Pocket Maximum</b> (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD. It excludes Prescription Drugs and the Emergency Room PVD. The In-Network Out-of-Pocket Maximum and Out-of-Network Out-of-Pocket Maximum are separate, and as such, accumulate separately and are applied separately.) (Any charges for non-covered services, benefit penalty reductions, charges in excess of any maximum benefit limitations, or charges in excess of the Allowed Amount are not included.)	\$2,500 / N/A \$5,000 / N/A
<b>Total Lifetime Maximum Benefit</b> (per person)	\$5,000,000

## Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual BlueOptions Contract. For a complete listing, please refer to the Contract.

- All services not specifically listed in the Contract or in any rider or endorsement, unless such services are specifically required by state law
- Any service which is not Medically Necessary
- Maternity care
- Elective cosmetic surgery
- Hearing aids or eyeglasses, vision or dental care, or oral appliances
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual BlueOptions Contract for details. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract. For a complete description of benefits and exclusions, please see the Contract.