

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 BlueChoice 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 |
| Deductible (DED) Embedded (DED is the amount the member must pay before Florida Blue pays) Individual Family | \$1,000 \$3,000 | Combined with In-Network Combined with In-Network |
| Coinsurance (Coinsurance is the percentage of the costs of a covered health care service a member pays, typically after the deductible is paid.) | 20% | 40% |
| Out-of-Pocket Maximum Embedded (Out-of-pocket maximum includes DED, coinsurance, copayments and prescription drugs) Individual Family | \$3,000 \$9,000 | Combined with In-Network Combined with In-Network |

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.

| Virtual Health Services | | Amount Member Pays | |
|--|-------------------------|-----------------------------|--|
| Benefit Description | In-Network | Out-of-Network | |
| Virtual Office Visits | | | |
| Primary Care Provider | \$0 Copay | Not Covered | |
| Specialist | \$15 Copay | Not Covered | |
| Behavioral Health (Mental Health/Substance Abuse) | | | |
| Primary Care Provider | \$0 Copay | Not Covered | |
| Specialist | \$0 Copay | Not Covered | |
| Office Services | | Amount Member Pays | |
| Benefit Description | In-Network | Out-of-Network | |
| Physician Office Services | | | |
| Primary Care Provider | \$20 Copay | DED + 40% | |
| Specialist | \$50 Copay | DED + 40% | |
| Maternity | | | |
| Primary Care Provider | \$20 Copay | DED + 40% | |
| Specialist | \$50 Copay | DED + 40% | |
| Allergy Injections (per visit) | | | |
| Primary Care Provider | \$5 Copay | DED + 40% | |
| Specialist | \$50 Copay | DED + 40% | |
| Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) | DED + 20% | DED + 40% | |
| Preventive Care | | Amount Member Pays | |
| Benefit Description | In-Network | Out-of-Network | |
| Adult Wellness Services | | | |
| Primary Care Provider | \$0 Copay | 40% | |
| Specialist | \$0 Copay | 40% | |
| Mammograms | \$0 Copay | \$0 Copay | |
| Routine Colonoscopy | \$0 Copay | 40% | |
| Child Wellness Services | | | |
| Primary Care Provider | \$0 Copay | 40% | |
| Specialist | \$0 Copay | 40% | |
| Emergency Medical Care | | Amount Member Pays | |
| Benefit Description | In-Network | Out-of-Network | |
| Urgent Care Centers | \$20 Copay | DED + \$20 | |
| Emergency Room | | | |
| Facility | \$250 Copay + DED + 20% | \$250 Copay + INN DED + 20% | |
| Physician Services | DED + 20% | INN DED + 20% | |
| Ambulance Services | DED + 20% | INN DED + 20% | |
| Outpatient Diagnostic Services | | Amount Member Pays | |
| Benefit Description | In-Network | Out-of-Network | |
| Independent Clinical Lab (e.g., Blood Work) | 20% | 40% | |
| Independent Diagnostic Testing Center (Includes provider services) | | | |
| Diagnostic Services (e.g., x-rays) | DED + 20% | DED + 40% | |
| Advanced Imaging Services (e.g., MRI, PET, CT) | DED + 20% | DED + 40% | |

| | | |
|-------------------------------------|-----------|-----------|
| Outpatient Hospital Facility | DED + 20% | DED + 40% |
|-------------------------------------|-----------|-----------|

| Hospital / Surgical | | Amount Member Pays | |
|---|-------------------|---|--|
| Benefit Description | In-Network | Out-of-Network | |
| Inpatient Services | | | |
| Facility | DED + 20% | \$300 Per Admission Deductible, then DED + 40% | |
| Radiologists, Anesthesiologists, and Pathologists | DED + 20% | INN DED + 20% | |
| All other Providers | DED + 20% | DED + 20% | |
| Outpatient Services | | | |
| Ambulatory Surgical Center | | | |
| Facility | DED + 20% | DED + 40% | |
| Provider Services | DED + 20% | DED + 40% | |
| Hospital | | | |
| Facility | DED + 20% | DED + 40% | |
| Radiologists, Anesthesiologists, and Pathologists | DED + 20% | INN DED + 20% | |
| All other Providers | DED + 20% | DED + 20% | |

| Behavioral Health (Mental Health / Substance Dependency) | | Amount Member Pays | |
|---|-------------------|---------------------------|--|
| Benefit Description | In-Network | Out-of-Network | |
| Physician Office Services | | | |
| Primary Care Provider | \$0 Copay | 40% | |
| Specialist | \$0 Copay | 40% | |
| Emergency Room | | | |
| Facility | \$0 Copay | \$0 Copay | |
| Physician services | \$0 Copay | \$0 Copay | |
| Inpatient Hospital Services | | | |
| Facility | \$0 Copay | 40% | |
| Physician services | \$0 Copay | \$0 Copay | |
| Outpatient Hospital Services | | | |
| Facility | \$0 Copay | 40% | |
| Physician services | \$0 Copay | \$0 Copay | |

| Other Services | | Amount Member Pays | |
|---------------------------------------|-------------------|---------------------------|--|
| Benefit Description | In-Network | Out-of-Network | |
| Durable Medical Equipment | | | |
| Motorized Wheelchairs | DED + 20% | DED + 40% | |
| All other | DED + 20% | DED + 40% | |
| Home Health Care | DED + 20% | DED + 40% | |
| Hospice | \$0 Copay | \$0 Copay | |
| Outpatient Therapy (per visit) | | | |
| Outpatient Rehabilitation Facility | DED + 20% | DED + 40% | |
| Outpatient Hospital Facility | DED + 20% | DED + 40% | |
| Prosthetic and Orthotics | DED + 20% | DED + 40% | |
| Skilled Nursing Facility | DED + 20% | DED + 40% | |

| Benefit Maximums | |
|---------------------------------|---|
| Home Health Care | 35 Visits |
| Outpatient Therapy | 35 Visits |
| Skilled Nursing Facility | 60 Days |
| Spinal Manipulations | 26 (accumulates towards the Outpatient Therapy maximum) |

Value Choice Providers

Florida Blue members have access to doctors that offer quality, coordinated care and may cost less for sick and wellness visits. With Value Choice Providers, members can expect extra help with tests and services, lower costs, and better coordinated care.

Value Choice Providers are only available in select counties and not all services are offered at every provider location. To find a Value Choice Provider, visit our online provider directory at FloridaBlue.com. Search for a primary care doctor. When you see the results, filter by program and select Value Choice Provider.

| Virtual Health Services | Amount Member Pays |
|--|---------------------------|
| Benefit Description | In-Network |
| Virtual Visits Value Choice Primary Care Provider Value Choice Specialist | \$0 Copay \$15 Copay |
| Office Services | Amount Member Pays |
| Benefit Description | In-Network |
| Physician Office Value Choice Primary Care Provider Value Choice Specialist | \$0 Copay \$25 Copay |
| Diagnostic Services (e.g., lab, x-rays) Value Choice Primary Care Provider Value Choice Specialist | \$0 Copay \$25 Copay |
| Advanced Imaging Services (e.g., MRI, PET, CT) Value Choice Primary Care Provider Value Choice Specialist | \$20 Copay DED + 20% |
| Emergency Medical Care | Amount Member Pays |
| Benefit Description | In-Network |
| Urgent Care Center | \$20 Copay |