BlueOptions
For Large Groups
Predictable Cost Health Plan 05771

Florida Blue
Your Health Solutions Partner

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**	
Benefit Description	**In-Network**	**Out-of-Network**
Deductible (DED) Embedded (DED is the amount the member must pay before Florida Blue pays) Individual Family	 $1,500 $4,500	 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	 $4,500 $13,500	 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.

70366-0825R E

Virtual Health Services	Amount Member Pays	
Benefit Description	**In-Network**	**Out-of-Network**
Virtual Office Visits		
Primary Care Provider	$25 Copay	Not Covered
Specialist	$55 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	$25 Copay	DED + 40%
Specialist	$55 Copay	DED + 40%
Maternity		
Primary Care Provider	$25 Copay	DED + 40%
Specialist	$55 Copay	DED + 40%
Allergy Injections (per visit)		
Primary Care Provider	$10 Copay	DED + 40%
Specialist	$55 Copay	DED + 40%
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 20%	DED + 40%
Medical Pharmacy administered in a Physician's Office	**Amount Member Pays**	
Benefit Description	**In-Network**	**Out-of-Network**
Medication		
Preferred	20%	DED + 40%
Non-Preferred	20%	DED + 40%
Monthly Out-of-Pocket (OOP) Maximum		
Preferred	Not Applicable	Not Applicable
Non-Preferred	Not Applicable	Not Applicable

Important Notes:

- 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.
- 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.

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	$0 Copay
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	$25 Copay	DED + $25 Copay
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)	$0 Copay	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%	INN 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%	INN 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
Inpatient Rehabilitation Therapy	30 Days
Outpatient Therapy	50 Visits
Skilled Nursing Facility	60 Days
Spinal Manipulations	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.