

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	
	In-Network	Out-of-Network
Deductible (DED) Shared (Deductible is the amount the member must pay before Florida Blue pays) Individual Family	 \$6,000 \$6,000	 \$10,000 \$10,000
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	 \$6,850 \$12,000	 \$23,200 \$23,200

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		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
Behavioral Health (Mental Health/Substance Abuse)			
Primary Care Provider		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
Office Services		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Physician Office Services			
Primary Care Provider		DED + 20%	DED + 40%
Specialist		DED + 20%	DED + 40%
Maternity			
Primary Care Provider		DED + 20%	DED + 40%
Specialist		DED + 20%	DED + 40%
Allergy Injections (per visit)			
Primary Care Provider		DED + 20%	DED + 40%
Specialist		DED + 20%	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		DED + 20%	DED + 50%
Non-Preferred		DED + 20%	DED + 50%
Monthly Out-of-Pocket (OOP) Maximum			
Preferred		Not Applicable	Not Applicable
Non-Preferred		Not Applicable	Not Applicable
Important Notes: <ul style="list-style-type: none"> 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	DED + 20%	DED + 20%	
Emergency Room			
Facility	DED + 20%	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)	DED	DED + 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%	\$500 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		DED + 20%	DED + 40%
Specialist		DED + 20%	DED + 40%
Emergency Room			
Facility		DED + 20%	INN DED + 20%
Physician services		DED + 20%	INN DED + 20%
Inpatient Hospital Services			
Facility		DED + 20%	INN DED + 20%
Physician services		DED + 20%	INN DED + 20%
Outpatient Hospital Services			
Facility		DED + 20%	DED + 40%
Physician services		DED + 20%	INN DED + 20%
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		DED + 20%	DED + 40%
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	20 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.