

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 HMO and is not considered 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.
- 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) Shared (DED is the amount the member must pay before Florida Blue HMO pays)		
Individual	\$3,400	Not Applicable
Family	\$4,000	Not Applicable
Coinsurance (Coinsurance is the percentage of the costs of a covered health care service a member pays, typically after the deductible is paid.)	20%	Not Applicable
Out-of-Pocket Maximum Embedded (Out-of-pocket maximum includes DED, coinsurance, copayments and prescription drugs)		
Individual	\$4,000	Not Applicable
Family	\$8,000	Not Applicable

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 HMO 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 HMO 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.

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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%	Not Covered
Specialist		DED + 20%	Not Covered
Maternity			
Primary Care Provider		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
Allergy Injections (per visit)			
Primary Care Provider		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)		DED + 20%	Not Covered
Medical Pharmacy administered in a Physician's Office		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Medication			
Preferred		DED + 20%	Not Covered
Non-Preferred		DED + 20%	Not Covered
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.			

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Preventive Care		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Adult Wellness Services			
Primary Care Provider		\$0 Copay	Not Covered
Specialist		\$0 Copay	Not Covered
Mammograms		\$0 Copay	Not Covered
Routine Colonoscopy		\$0 Copay	Not Covered
Child Wellness Services			
Primary Care Provider		\$0 Copay	Not Covered
Specialist		\$0 Copay	Not Covered
Emergency Medical Care		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Urgent Care Centers		DED + 20%	Not Covered
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 + 20%	Not Covered
Independent Diagnostic Testing Center (Includes provider services)			
Diagnostic Services (e.g., x-rays)		DED + 20%	Not Covered
Advanced Imaging Services (e.g., MRI, PET, CT)		DED + 20%	Not Covered
Outpatient Hospital Facility		DED + 20%	Not Covered
Hospital / Surgical		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Inpatient Services			
Facility		DED + 20%	Not Covered
Radiologists, Anesthesiologists, and Pathologists		DED + 20%	Not Covered
All other Providers		DED + 20%	Not Covered
Outpatient Services			
Ambulatory Surgical Center			
Facility		DED + 20%	Not Covered
Provider Services		DED + 20%	Not Covered
Hospital			
Facility		DED + 20%	Not Covered
Radiologists, Anesthesiologists, and Pathologists		DED + 20%	Not Covered
All other Providers		DED + 20%	Not Covered

Behavioral Health (Mental Health / Substance Dependency)		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Physician Office Services			
Primary Care Provider		DED + 20%	Not Covered
Specialist		DED + 20%	Not Covered
Emergency Room			
Facility		DED + 20%	INN DED + 20%
Physician services		DED + 20%	INN DED + 20%
Inpatient Hospital Services			
Facility		DED + 20%	Not Covered
Physician services		DED + 20%	Not Covered
Outpatient Hospital Services			
Facility		DED + 20%	Not Covered
Physician services		DED + 20%	Not Covered
Other Services		Amount Member Pays	
Benefit Description		In-Network	Out-of-Network
Durable Medical Equipment			
Motorized Wheelchairs		DED + 20%	Not Covered
All other		DED + 20%	Not Covered
Home Health Care		DED + 20%	Not Covered
Hospice		DED + 20%	Not Covered
Outpatient Therapy (per visit)			
Outpatient Rehabilitation Facility		DED + 20%	Not Covered
Outpatient Hospital Facility		DED + 20%	Not Covered
Prosthetic and Orthotics		DED + 20%	Not Covered
Skilled Nursing Facility		DED + 20%	Not Covered
Benefit Maximums			
Home Health Care	Unlimited		
Inpatient Rehabilitation Therapy	30 Days		
Outpatient Therapy	60 Visits		
Skilled Nursing Facility	Unlimited		
Spinal Manipulations	20 (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.

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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		DED
Value Choice Specialist		DED
Office Services		Amount Member Pays
Benefit Description		In-Network
Physician Office		
Value Choice Primary Care Provider		DED
Value Choice Specialist		DED
Diagnostic Services (e.g., lab, x-rays)		
Value Choice Primary Care Provider		DED
Value Choice Specialist		DED
Advanced Imaging Services (e.g., MRI, PET, CT)		
Value Choice Primary Care Provider		DED
Value Choice Specialist		DED
Emergency Medical Care		Amount Member Pays
Benefit Description		In-Network
Urgent Care Center		DED