BlueOptions **with Integrated Prescription Drug Coverage**

Schedule of Benefits - Plan 05169 Family Coverage

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period..... **01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$4,200	$8,400
Per Family per Benefit Period	$4,200	$8,400
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	0%	20%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$4,200	$16,800
Per Family per Benefit Period	$4,200	$16,800

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the DED and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office Visits rendered by		
Family Physicians	DED	DED + 20%
Other health care professionals licensed to perform such Services	DED	DED + 20%
Allergy Injections rendered by		
Family Physicians	DED	DED + 20%
Other health care professionals licensed to perform such Services	DED	DED + 20%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	DED	DED + 20%
Other health care professionals licensed to perform such Services.	DED	DED + 20%
E-Visits rendered by		
Family Physicians	DED	DED + 20%
Other health care professionals licensed to perform such Services	DED	DED + 20%
Durable Medical Equipment, Prosthetics, and Orthotics	DED	DED + 20%
Convenient Care Centers	DED	DED + 20%

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Rendered by		
Family Physicians	$0	20%
Other health care professionals licensed to perform such Services	$0	20%
All other locations	$0	20%
Well Woman Services, subject to the Preventive Adult Wellness Maximum, if any rendered by		
Family Physicians	$0	20%
Other health care professionals licensed to perform such Services	$0	20%
All other locations	$0	20%
Child Health Supervision Services rendered by		
Family Physicians	$0	20%
Other health care professionals licensed to perform such Service	$0	20%
All other locations	$0	20%
Mammograms	$0	$0
Routine Colonoscopies	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 20%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED	DED + 20%
All other diagnostic Services (e.g., X-rays)	DED	DED + 20%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED	DED + 20%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center		
Facility (per visit)	DED	DED + 20%
Radiologists, Anesthesiologists, and Pathologists	DED	In-Network DED
Physician and other health care professional Services rendered by all other Providers	DED	DED + 20%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED	DED	DED + 20%
Physician and other health care professional Services	DED		In-Network DED
Outpatient			
Facility (per visit)	DED	DED	DED + 20%
Physician and other health care professional Services	DED		In-Network DED
Therapy Services	DED	DED	DED + 20%
Emergency Room Visits			
Facility	DED		DED
Physician and other health care professional Services	DED		In-Network DED

Important:

Certain categories of Providers may not be available In-Network in all geographic areas, including, but not limited to, anesthesiologists, radiologists, pathologists and emergency room Physicians. This plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level (Cost Share amounts listed in the "In-Network" column). If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not a Traditional Program Provider, you will be responsible for the difference between what the Plan pays and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

*****Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

BlueScript® Pharmacy Program

All Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network DED**, which must be satisfied by you before any payment will be made by us. To verify if a Pharmacy is a Participating Pharmacy, you may access a current pharmacy directory, refer to our website at www.floridablue.com, or call the customer service phone number on your Benefit Booklet or Identification Card.

Retail Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a One-Month Supply	DED + $0	DED + 50%
Preferred Brand Name Prescription Drugs or Supplies For up to a One-Month Supply	DED + $0	DED + 50%
Non-Preferred Prescription Drugs or Supplies For up to a One-Month Supply	DED + $0	DED + 50%
Mail Order Pharmacy	***Participating Pharmacy**	****Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs For up to a Three-Month Supply	DED + $0	DED + 50%
Preferred Brand Name Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $0	DED + 50%
Non-Preferred Prescription Drugs or Supplies For up to a Three-Month Supply	DED + $0	DED + 50%

Specialty Pharmacy	*Participating Pharmacy	**Non-Participating Pharmacy
Preferred Generic Prescription Drugs and Covered OTC Drugs		
For up to a One-Month Supply	DED + $0	DED + 50%
Preferred Brand Name Prescription Drugs or Supplies		
For up to a One-Month Supply	DED + $0	DED + 50%
Non-Preferred Prescription Drugs or Supplies		
For up to a One-Month Supply	DED + $0	DED + 50%

* Our payment for Covered Prescription Drugs is based on the **Participating Pharmacy Allowance.**

** Our payment for Covered Prescription Drugs is based on the **Non-Participating Pharmacy Allowance** and may be less than the cost of the Drug or Supply. You are responsible for any charges in excess of the Non-Participating Pharmacy Allowance for purchases at Non-Participating Pharmacies.

Important information affecting the amount you will pay for Prescription Drugs:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide; Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**

  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only "Participating Pharmacy" suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us in the Medication Guide as a Specialty Pharmacy is considered a Non-Participating Pharmacy for payment purposes under this BlueScript Pharmacy Program.

- Some Specialty Drugs may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.

- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

- You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) at three times the Cost Share amount you would be required to pay at a retail Participating Pharmacy. This note does not apply to Specialty Drugs, which are covered only up to a One-Month Supply.

- Amounts incurred for Covered Prescription Drugs, Over-The-Counter Drugs and Covered Prescription Supplies will be applied to the In-Network Out-of-Pocket Maximum as indicated in this Schedule of Benefits.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room	DED	In-Network DED
Hospital	DED	DED + 20%
Physician Services at Hospital and ER	DED	In-Network DED
Physician and other health care professionals licensed to perform such Services rendered at: Family Physician office	DED	DED + 20%
Specialist office	DED	DED + 20%
All other locations	DED	DED + 20%
Inpatient Facility Services	DED	DED + 20%
Physicians and other health care professionals licensed to perform such Services	DED	In-Network DED

Benefit Maximums

Home Health Care Visits per Benefit Period..... 20

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 35
Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility Days per Benefit Period..... 60

Wigs per Covered Plan Participant per Lifetime..... $500

Note: Covered expenses are not subject to the DED. Coinsurance amounts and any applicable Copayments will apply.

Additional Benefits/Features

Benefit Maximum Carryover
If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.