BlueSelect
For Individuals Under 65
Benefit Summary for Health Plan 225

FLORIDA
An Independent Licensee of the Blue Cross and Blue Shield Association

Understanding Your Share for Covered Services

This health insurance policy[1] provides you with routine health care services, such as physician office services, as well as basic protection against major illnesses requiring hospitalization or surgery. We encourage you to carefully review what the plan covers and understand what your out-of-pocket costs may be.

BlueSelect[2] is the Preferred Provider Network / Exclusive Provider designated as "In-Network" for BlueSelect.

Benefits for Covered Services	Amount Member Pays
▶ Office Services	
Physician Office Services (Includes e-office visits, allergy injections, in-office surgery, and Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network Family Physician	Balance[3] up to Allowed Amount[4] after BCBSF pays up to $50
In-Network Specialist	Balance up to Allowed Amount after BCBSF pays up to $75
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Maternity Initial Visit With many plans a maternity option is available – you can choose to add an endorsement, at an additional rate, that provides benefits for pregnancy and delivery (the endorsement must be in effect for 30 days prior to conception).	Available
▶ Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network Provider	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Mammograms	
In-Network	$0
Out-of-Network	CYD[5] + 50% Coinsurance[6]
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network	$0
Out-of-Network	CYD + 50% Coinsurance
▶ BlueSelect Pharmacy	
For the greatest savings on your prescriptions, always check to see if the pharmacy is in the BlueSelect network. Your medication will cost you less if you stay in-network. We have identified certain drugs as a 'specialty drug'. These drugs are listed as a 'specialty drug' in the BlueSelect Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a BlueSelect Pharmacy.	

1 Policies have limitations and exclusions and are medically underwritten.
2 The BlueSelect Network is our Preferred Provider/Exclusive Provider Network made up of independent hospitals, physicians and ancillary providers.
3 "Balance" is the difference between our payment and the amount an In-Network provider agrees to accept as payment in full for covered services (the allowed amount). For Out-of-Network providers, "balance" is the difference between our payment (allowed amount) and the provider's charge. You are responsible for paying the doctor or provider this "balance".
4 The Allowed Amount is the amount we have negotiated with providers for payment of covered services, instead of a member paying the full charge for a service.
5 CYD = Calendar Year Deductible —The amount, if any, per calendar year, you owe before we begin to pay for covered services.
6 Coinsurance is the percentage the member pays for service.

Note: Out-of-Network services may be subject to balance billing.

Benefits for Covered Services	Amount Member Pays
▶ BlueSelect Pharmacy (Continued)	
Pharmacy Deductible (PD)	$800 (Brand Only)
In-Network Prescription Drug Program	
Retail and Specialty Pharmacy – Generic / Brand / Non-Preferred	$10 Copayment / PD + $60 Copayment / Not Covered
Mail Order (90 days) – Generic / Brand / Non-Preferred	$25 Copayment / PD + $150 Copayment / Not Covered
Out-of-Network Prescription Drug Program	
Retail and Specialty Pharmacy–Generic / Brand / Non-Preferred	50% Coinsurance / PD + 50% Coinsurance / Not Covered
Mail Order (90 days) – Generic / Brand / Non-Preferred	50% Coinsurance / PD + 50% Coinsurance / Not Covered
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 Deductible and the Copayment or Coinsurance applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueSelect Pharmacy Program Schedule of Benefits. BlueSelect Pharmacy benefit also provides coverage for Prescription oral contraceptives, Prescription diaphragms and diabetic equipment and supplies. **Note: Not all Brand Name prescription drugs are covered. Please refer to the Closed Formulary Medication Guide for which Brand Name prescription drugs are covered. If you want to purchase a specific drug not listed on the Medication Guide, you will be responsible for the full cost of the drug.**	
▶ Emergency Medical Care	
Urgent Care Centers	
In-Network	Balance up to Allowed Amount after BCBSF pays up to $50
Out-of-Network	Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
Emergency Room Facility Services (ER) (per visit)	
If Admitted or if a surgical service is performed	
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
Non-Surgical Services	
Per Visit Deductible (PVD)	$750
In-Network and Out-of-Network	PVD + In-Network CYD + 10% Coinsurance
Ambulance Services (Ground / air and water travel, per day maximum)	$5,000
In-Network and Out-of-Network	In-Network CYD + 10% Coinsurance
▶ Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (Except AIS)	$75 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	$150 Copayment
Out-of-Network	CYD + 50% Coinsurance
Outpatient Hospital Facility Services[7] (per visit) (Services Related to Surgery Only) (e.g. proximately related Blood Work and X-rays)	
In-Network	$400 Copayment
Out-of-Network	CYD + 50% Coinsurance

7 Includes services rendered at a Hospital, Psychiatric Facility or Substance Abuse Facility.

Benefit Summary for Health Plan 225

Benefits for Covered Services	Amount Member Pays
▶ Other Provider Services	
Provider Services at Hospital and ER If Admitted or if a surgical service is performed In-Network and Out-of-Network Non-Surgical ER Services Per Visit Deductible (PVD) In-Network and Out-of-Network	 In-Network CYD + 10% Coinsurance $750 PVD + In-Network CYD + 10% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	 In-Network CYD + 10% Coinsurance
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network Provider	 Balance up to Allowed Amount after BCBSF pays up to $50 Balance up to Allowed Amount after BCBSF pays up to $75 Balance up to the Allowed Amount for Traditional Network providers, or the balance of the provider's charge for non-par providers after BCBSF pays up to $50
▶ Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY[8] max) Locations other than Hospital and Physician's Office In-Network Out-of-Network Outpatient Hospital Facility	 25 Visits CYD + 10% Coinsurance CYD + 50% Coinsurance Not Covered
Skilled Nursing Facility (PCY max) In-Network Out-of-Network	45 Days CYD + 10% Coinsurance CYD + 50% Coinsurance
Hospice In-Network Out-of-Network	 CYD + 10% Coinsurance CYD + 50% Coinsurance
▶ Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) (Services Related to Surgery Only) In-Network Out-of-Network	 CYD + 10% Coinsurance CYD + 50% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) In-Network Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation Services limit - 21 days PCY $2,500 Copayment $700 PAD + CYD + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) (Services Related to Surgery Only) In-Network Out-of-Network	 $400 Copayment CYD + 50% Coinsurance
Emergency Room Facility Services (ER) (per visit) If Admitted or if a surgical service is performed In-Network and Out-of-Network Non-Surgical Services Per Visit Deductible (PVD) In-Network and Out-of-Network	 In-Network CYD + 10% Coinsurance $750 PVD + In-Network CYD + 10% Coinsurance

8 PCY = Per Calendar Year

BlueSelect
For Individuals Under 65
Benefit Summary for Health Plan 225

Benefits for Covered Services	Amount Member Pays
▶ Exclusive Provider Organization Services (EPO)	
Please keep in mind that with BlueSelect there are certain services and supplies that are covered ONLY if you see the Exclusive providers within the BlueSelect network. It is very important that you consider the cost impact if you are thinking of choosing a different provider than one of the Exclusive providers designate for the following services. If you do, you will have to pay the entire bill.	
Independent Clinical Lab (e.g. blood work) In-Network Out-of-Network	 $ 0 **No Coverage**
Mental Health (Inpatient PCY / Outpatient PCY) **Substance Dependency** Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network Provider Services a Hospital and ER In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	8 Days / 8 Visits $2,500 Copayment **No Coverage** $55 Copayment **No Coverage** $400 Copayment **No Coverage** $55 Copayment **No Coverage**
Durable Medical Equipment, Prosthetics and Orthotics (If proximately related to surgery, Inpatient Admissions or ER services only) In-Network Out-of-Network	 $0 **No Coverage**
Home Health Care (PCY max) In-Network Out-of-Network	45 Visits $0 **No Coverage**
▶ Dental Coverage	
Preventive and Basic Dental Services Includes coverage for services such as routine oral exams and cleanings 2 times/yr, bitewing x-rays once/yr, and fluoride for children 2 times/yr, fillings and denture repairs. In-Network Out-of-Network	 Balance up to Allowed Amount after BCBSF pays up to $50 Balance up to the provider's charge after BCBSF pays up to $50
▶ Financial Features	
Calendar Year Deductible (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays)	 $250 / N/A $750 / N/A
Per Admission Deductible (PAD) (Out-of-Network Inpatient Hospital Facility Services)	 $700
Emergency Room Non-Surgical Per Visit Deductible (PVD) (Facility and Physician Services) In-Network and Out-of-Network	 $750

BlueSelect
For Individuals Under 65
Benefit Summary for Health Plan 225

Benefits for Covered Services	Amount Member Pays
▶ **Financial Features (Continued)**	
Coinsurance (Member pays) In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 10% of the Allowed Amount 50% of the Allowed Amount (+ the balance of provider's charge for non-par providers)
Out-of-Pocket Maximum (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximums include CYD, Coinsurance, Copayments and PAD; Excludes Prescription Drugs, Emergency Room PVD, and the balance after BCBSF maximum payment of $50 or $75.) The In-Network Out-of-Pocket Maximum and Out-of-Network Out-of-Pocket Maximum are separate, and as such, accumulate separately and are applied separately.) (Any non-covered charges, benefit penalty reductions, charges in excess of any maximum benefit limitations, or charges in excess of the Allowed Amount are not included.)	 $2,500 / N/A $5,000 / N/A
Total Lifetime Maximum Benefit (per member)	No Maximum

For added peace of mind, your dependents may be covered as long as you maintain your BlueSelect policy with us. Ask for complete details since some restrictions apply.

Exclusive Providers within the BlueSelect network.

You do not need a referral to receive care from a BlueSelect provider. However, please remember that if you do not receive care from an Exclusive Provider for the services identified below, you will be responsible for the full charge (except in certain situations such as emergencies). It pays to stay in-network and use an Exclusive Provider for covered:

- **Clinical Laboratory Tests** ordered by a doctor (no cost to you)
- **Home Health Services** such as visiting nurses, physical therapy, speech-language therapy, and occupational therapy (no cost to you)
- **Behavioral Health Care and Substance Dependency Services**
- **Durable Medical Equipment and Medical Supplies** that a provider may order as part of treatment or supplied as a service (no cost to you)

BlueSelect pharmacy options.

There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—**retail pharmacies and specialty pharmacies.** To be covered under your pharmacy program at the lowest cost, before you get a prescription filled you should **confirm which pharmacy is considered 'in-network' for that particular medication.** We encourage you to go to our online provider directory to locate an in-network pharmacy for your particular medication.

Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual BlueSelect Contract. For a complete description of benefits and exclusions, please see the BlueSelect Contract.

- All services not specifically listed in the Contract or in any rider or endorsement, unless such services are specifically required by state law
- Any service which is not Medically Necessary
- Maternity care
- Elective cosmetic surgery
- Hearing aids or eyeglasses, vision or dental care, or oral appliances
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care

Services subject to an Exclusive Provider Provision rendered or supplied by any Provider **other than the Provider designated solely by us as the Exclusive Provider of such services**, except for Emergency Services and Care for the treatment of an Emergency Medical Condition. Please refer to your Schedule of Benefits to determine which services are subject to an Exclusive Provider Provision.

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual BlueSelect Contract for details. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida, Inc. (BCBSF), an independent licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract.

Important information regarding BlueSelect coverage

Certain services, such as Advanced Imaging Services and Specialty Drugs, require prior authorization before obtaining the service. While it is your responsibility to confirm the network participation status of a provider before you receive the service, it is the par provider's responsibility to obtain the prior authorization. If there is no prior authorization on file, it will result in the claim being denied. If you choose to see a non-participating provider for certain services such as Advanced Imaging Services, you may have an obligation to ensure an authorization is on file to receive full coverage for the service. Please see your Contract to understand when you may need to take steps to ensure full benefit access.

You have the right to appeal: BCBSF has a quality assurance program in place to assess the services of Exclusive providers. Quality assurance includes formal review of care, problem identification, corrective actions and evaluation of actions taken.

How to Appeal an Adverse Benefit Determination or a Grievance: You have the right to appeal an Adverse Benefit Determination or file a Grievance with us. Your appeal or grievance will be reviewed using the review process described in your contract. It must be submitted to us in writing for an internal appeal within 365 days of the original appeal. But if it's a Concurrent Care Decision, it may require you to file within a shorter period of time from notice of the denial.

Subscriber Assistance Program: The Subscriber Assistance Program (SAP) is a State of Florida program available to assist you with grievances that have not been satisfactorily resolved.