BlueOptions – Prime Plus Plan

Schedule of Benefits – Plan 03766

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.
- GatorCare features a panel of Providers designated as In-Network (Tier 1) for your plan. Network Blue is the panel of Providers designated as Tier 2 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 on site representative or access the Provider directory at http://gatorcare.org. If you receive Covered Services outside the state of Florida from Blue Card® participating Providers, payment will be made based on the tier 2 level of benefits.
- References to Benefit Period 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	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Deductible (DED)			
Per Person per Benefit Period	$400	$1,500	Not Covered
Per Family per Benefit Period	$800	$3,000	Not Covered
Per Admission Deductible (PAD)	$0	$1,500	Not Applicable
Emergency Room Per Visit Deductible (PVD) (waived if admitted)	$150	$250	$250
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	10%	40%	Not Covered
Out-of-Pocket Maximums			
Per Person per Benefit Period	$2,600	$6,850	Not Covered
Per Family per Benefit Period	$5,200	$13,700	Not Covered

Deductible amounts incurred for GatorCare Network Services will only be applied to the amounts listed in the Tier 1 column. Amounts incurred for Network Blue Services will be applied to the amounts listed in the Tier 1 and Tier 2 column, and amounts incurred for Out-of-Network Services will be applied to the amounts listed in the Tier 1, Tier 2, and Tier 3 column, unless otherwise indicated within this Schedule of Benefits.

Out-of-Pocket Maximum amounts will cross accumulate between all tiers.

What **applies** to out-of-pocket maximums?	• DED • Coinsurance • Copayments • PAD, when applicable • PVD, when applicable • Any Prescription Drug Cost Share amounts
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.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

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, Obstetrics/Gynecology**,** and Pediatrics.

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Office visits and Services not otherwise outlined in this table rendered by			
Family Physicians	$15	DED + 40%	Not Covered
Specialist Office	$35	DED + 40%	Not Covered
Advanced Imaging Services* (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) and **All other diagnostic Services** (e.g., Lab, X-rays) rendered by			
Family Physicians	$15	DED + 40%	Not Covered
Specialist Office	$35	DED + 40%	Not Covered
Allergy Injections rendered by			
Family Physicians	$15	DED + 40%	Not Covered
Specialist Office	$35	DED + 40%	Not Covered
E-Visits rendered by			
Family Physicians	$15	DED + 40%	Not Covered
Specialist Office	$35	DED + 40%	Not Covered
Virtual Visits rendered by			
Family Physicians	$10	Not Covered	Not Covered
Specialist Office	$20	Not Covered	Not Covered
Disease Management Initial Assessment and Program Initiation	$0	Not Covered	Not Covered
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	Tier 1 DED + 20%	Not Covered
Maternity (Initial visit)	$15	DED + 40%	Not Covered
Nurse Practioner	$15	DED + 40%	Not Covered
Chiropractic	$35	$35	Not Covered
Convenient Care Centers	Not Covered	Not Covered	Not Covered

***Prior Coverage Authorization is required for these services.

Preventive Health Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Adult Wellness Services Rendered by Family Physicians	$0	DED + 40%	Not Covered
Specialist Office	$0	DED + 40%	Not Covered
All other locations	$0	DED + 40%	Not Covered
Adult Well Woman Services Rendered by Family Physicians	$0	DED + 40%	Not Covered
Specialist Office	$0	DED + 40%	Not Covered
All other locations	$0	DED + 40%	Not Covered
Well Child Services Rendered by Family Physicians	$0	DED + 40%	Not Covered
Specialist Office	$0	DED + 40%	Not Covered
All other locations	$0	DED + 40%	Not Covered
Mammograms	$0	DED + 40%	Not Covered
Routine Colonoscopy	$0*	DED + 40%	Not Covered

*Beginning on the 1st of the year, $0 Copay applies to all locations of Service and Provider related Services with no age limitations. Any subsequent services within the same year will resume normal member cost shares.

Outpatient Diagnostic Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Independent Clinical Lab	10%	DED + 40%	Not Covered
Independent Diagnostic Testing Facility Advanced Imaging Services* (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	10%	DED + 40%	Not Covered
All other diagnostic Services (e.g., X-rays)	10%	DED + 40%	Not Covered
Outpatient Hospital Facility	See **Hospital Services Outpatient**		

***Prior Coverage Authorization is required for these services.

Emergency and Urgent Care Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Ambulance Services	Tier 1 DED + 20%		
Emergency Room Visits	See **Hospital Services Emergency Room Visits**		
Urgent Care Center	$35	DED + 40%	Not Covered

Outpatient Surgical Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Ambulatory Surgical Center Facility (per visit)	10%	DED + 40%	Not Covered
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	DED + 40%	Not Covered
Physician and other health care professional Services	DED + 10%	DED + 40%	Not Covered
Outpatient Hospital Facility	See **Hospital Services Outpatient**		

Hospital Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Inpatient			
Facility Services (per admission)	DED + 10%	$1,500 PAD + DED + 40%	Not Covered
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	DED + 40%	Not Covered
Physician and other health care professional Services	DED + 10%	DED + 40%	Not Covered
Outpatient			
Facility (per visit)	DED + 10%	DED + 40%	Not Covered
Radiologists, Anesthesiologists, and Pathologists	DED + 10%	DED + 40%	Not Covered
Physician and other health care professional Services	DED + 10%	DED + 40%	Not Covered
Diagnostic Colonoscopy	DED + 10%*	DED + 40%	Not Covered
Advanced Imaging Services**(CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) and All other diagnostic Services (e.g.,Lab, X-rays)	10%	DED + 40%	Not Covered
Therapy Services	10%	DED + 40%	Not Covered
Emergency Room Visits			
Facility (PVD waived if admitted)	$150 PVD + DED + 10%	$250 PVD + DED + 10%	$250 PVD + Tier 2 DED + 10%
ER Physicians	DED + 10%	DED + 10%	Tier 2 DED + 10%

***Beginning on the 1st of the year, $0 Copay applies to all locations of Service and Provider related Services with no age limitations. Any subsequent services within the same year will resume normal member cost shares.

****Prior Coverage Authorization is required for these services.

Important:

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

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

Behavioral Health Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Mental Health and Substance Dependency Care and Treatment Services			
Outpatient			
Facility Services rendered at:			
Emergency Room (PVD waived if admitted)	$150 PVD + DED + 10%	$250 PVD + DED + 10%	$250 PVD + Tier 2 DED + 10%
Hospital	DED + 10%	DED + 40%	Not Covered
Physician Services at ER	DED + 10%	DED + 10%	Tier 2 DED + 10%
Physician Services at Hospital	DED + 10%	DED + 40%	Not Covered
Physician and other health care professionals licensed to perform such Services			
Family Physician office	$15	DED + 40%	Not Covered
Specialist office	$35	DED + 40%	Not Covered
All other locations	DED + 10%	DED + 40%	Not Covered
Inpatient			
Facility Services	DED + 10%	$1,500 PAD + DED + 40%	Not Covered
Physician Services at Hospital	DED + 10%	DED + 40%	Not Covered

Other Services

Benefit Description	GatorCare Network Tier 1	Network Blue Tier 2	Out-of-Network Tier 3
Birthing Center	DED + 10%	DED + 40%	Not Covered
Diabetic Equipment	DED + 20%	Tier 1 DED + 20%	Not Covered
Diabetic Self Management/ Education	10%	DED + 40%	Not Covered
Dialysis	DED + 10%	DED + 40%	Not Covered
Enteral Formula	DED + 20%	Tier 1 DED + 20%	Not Covered
Home Health Care	10%	DED + 40%	Not Covered
Hospice	DED + 10%	DED + 40%	Not Covered
Outpatient Rehabilitation Facility	10%	DED + 40%	Not Covered
Skilled Nursing Facility	DED + 10%	DED + 40%	Not Covered
Wigs (Cranial Prosthesis)	DED + 20%	Tier 1 DED + 20%	Not Covered

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Benefit Maximums

Home Health Care Visits per Benefit Period..... 30

Inpatient Rehabilitation days per Benefit Period..... 21

Outpatient Therapies Visits per Benefit Period..... 75

Note: Refer to the Benefit Booklet for reimbursement guidelines.

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

Spinal Manipulations (combined with Outpatient Therapies) Visits per Benefit Period..... 26