

# **BlueChoice**

**Schedule of Benefits**  
**Plan 730**

# BlueChoice

## Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits. This plan provides coverage for certain Physician office services, without having to satisfy a Calendar Year Deductible (CYD) requirement, when obtained from a PPO Physician. This plan also provides coverage for adult wellness services without having to satisfy a Calendar Year Deductible requirement. Financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities **may vary** depending upon the Providers chosen by the Covered Plan Participant.

### A. Deductible and Coinsurance Amounts

Benefit Description	PPO	Providers Not Participating in PPO
Individual Calendar Year Deductible (CYD) <b>Note:</b> The Individual CYD will be waived for Health Care Services rendered by any Independent Clinical Laboratory.	\$750	
Family Calendar Year Deductible (CYD)	\$2,250	
Hospital Per Admission Deductible (PAD)	\$0 In addition to the CYD and applicable Coinsurance	\$0 In addition to the CYD and applicable Coinsurance
Emergency Room Per Visit Deductible	\$50	\$50
Coinsurance Payable by the Plan for Emergency Room Services	100% of the Allowed Amount	100% of the Allowance
Coinsurance Percentage Payable	80% of the Allowed Amount	60% of the Allowance
Coinsurance Payable by the Plan for Ambulance Services	80% of the Allowance	
Individual Coinsurance Responsibility Limit Per Calendar Year	\$2,000	
Family Coinsurance Responsibility Limit Per Calendar Year	\$6,000	
<b>Note:</b> Coinsurance Responsibility Limits do not include the CYD amount, the Emergency Room Per Visit Deductible amount, the Copayment, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.		

**B. Office Services**

<b>Benefit Description</b>	<b>PPO</b>	<b>Providers Not Participating in PPO</b>
Office Services rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	\$20 Copayment per visit*	60% Coinsurance after CYD
Office Services rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such services.	\$35 Copayment per visit*	60% of the Allowance after CYD
Coinsurance Payable by the Plan for Child Health Supervision Services	100% of the Allowed Amount	60% of the Allowance
Maternity Services	\$20 for the initial visit and then 100% of the Allowed Amount	60% of the Allowance after CYD
Allergy Injections	\$0 Copayment per visit*	100% of the Allowance
Biofeedback	100% of the Allowed Amount	100% of the Allowance
Durable Medical Equipment, Prosthetics and Orthotics, and wigs after chemotherapy	80% of the Allowed Amount after CYD	60% of the Allowance after CYD
*These Services are subject to the Copayment only.		
<b>Note:</b> A Covered Plan Participant should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, a Covered Plan Participant may access the PPO Provider directory at our website at <a href="http://www.bcbsfl.com">www.bcbsfl.com</a> , contact the local BCBSF office, or review the most recent Provider Directory.		

**C. Benefit Maximums**

**Accumulated Total Lifetime Maximum Benefit** Per Covered Plan Participant ..... \$2,000,000

**Adult Wellness** Per Covered Plan Participant Per Calendar Year..... \$200

Covered Services as described below for an adult. For purposes of this benefit an adult is 17 years or older.

Adult Wellness services include:

- 1. annual physical or gynecological exam (including family planning/contraceptive Services); and
- 2. related wellness services including, but not limited to, flu shots, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory services, and immunizations. Routine vision and hearing examinations and screenings are not covered.

**Note:** The wellness services above are not subject to the CYD, but are subject to the Copayment or the applicable Coinsurance based on the location of service and the Provider's participating status.

**Bereavement Counseling** Per Covered Plan Participant

Per Lifetime .....6 visits not to exceed a maximum of \$250

**Enteral Formulas** Per Covered Plan Participant Per Calendar Year ..... \$2,500

**Home Health Care** Per Covered Plan Participant Per Calendar Year ..... \$5,000

**Hospice** (Combined Inpatient, Outpatient and Home)

Per Covered Plan Participant Per Lifetime ..... \$5,000

**Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies** Visits Per Covered Plan Participant Per Calendar Year ..... 60

**Note:** Refer to the Evidence of Coverage for reimbursement guidelines.

**Skilled Nursing Facility** Days Per Covered Plan Participant Per Calendar Year..... 90

**Spinal Manipulations** Per Covered Plan Participant Per Calendar Year ..... \$500

**TMJ- services** Per Covered Plan Participant Per Calendar Year ..... \$500  
or 18 visits, whichever occurs first

**Transplant Coverage for Lodging, Meals and Transportation**

Per Covered Plan Participant Per Lifetime ..... \$10,000

**Note:** If immediately before the Effective Date of the Group, a Covered Plan Participant was covered under a prior group policy issued or administered by BCBSF to the Group, amounts applied to a Covered Plan Participant's Calendar Year benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward the Covered Plan Participant's Calendar Year benefit maximums and lifetime maximums under the Evidence of Coverage.

#### **D Admission Certification Requirements**

All Hospital admissions in the state of Florida must be certified. The following penalties will apply for admissions within the state of Florida which are not certified.

1. Admissions to a Hospital that is a PPC Provider - No penalty for the Covered Plan Participant. It is the responsibility of the PPC Hospital/Physician to obtain admission certification.
2. Hospitals that are not BCBSF Providers - any non-certified admissions in the state of Florida are subject to a 25% benefit penalty reduction. The Covered Plan Participant is responsible for obtaining certification for the admission from BCBSF and for any applicable benefit reductions for failure to obtain such certification.

#### **E. Prescription Drug Program**

Please refer to the pharmacy program Endorsement for additional information concerning your Prescription Drug Program.