

BlueChoice PPO Grandfathered Plan

Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits, which is part of the Evidence of Coverage, to be aware of important information concerning the Covered Plan Participant's share of the expenses for Covered Services. The Covered Plan Participant's share of the expenses, including any applicable Deductibles and Coinsurance responsibilities, **will vary** depending upon the Provider the Covered Plan Participant chooses and the setting in which the Services are rendered. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

Benefit Period (BP) 1/1 – 12/31

Deductible and Coinsurance Amounts

Benefit Description	PPO	Providers Not Participating in PPO
Individual Deductible (DED) Note: The Individual DED will be waived by BCBSF for Health Care Services rendered by any Independent Clinical Laboratory.	\$750	
Family Benefit Period Deductible (DED)	\$2,250	
Amount Payable by the Plan	80% of the Allowed Amount	60% of the Allowed Amount
Amount Payable by the Plan for Ambulance Services	80% of the Allowed Amount after DED	
Amount Payable by the Plan for Mammograms (Routine and with diagnosis)	100% of the Allowed Amount, DED waived	
Individual Coinsurance Responsibility Limit per BP	\$2,000	
Family Coinsurance Responsibility Limit per BP	\$6,000	
Note: Coinsurance Responsibility Limits do not include the DED amount, the Hospital PAD 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.		

Office Services

Benefit Description	PPO	Providers Not Participating in PPO
Office Services Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	\$20 Copayment per visit*	60% of the Allowed Amount after DED
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 Allowed Amount after DED
Well Child Care	100% of the Allowed Amount	60% of the Allowed Amount, DED waived
Prenatal Exam	\$20 Copayment for the initial visit then 100% of the Allowed Amount	\$20 Copayment for initial visit then 60% of the Allowed Amount
Allergy testing rendered by: 1. Family Practice, General Practice, Internal Medicine, and Pediatrics 2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such services.	\$20 Copayment per visit* \$35 Copayment per visit*	60% of the Allowed Amount after DED 60% of the Allowed Amount after DED
Allergy Injections Note: Administered at Physician's office	100% of the Allowed Amount	100% Allowed Amount after DED
Durable Medical Equipment, Prosthetics and Orthotics, and Wigs after chemotherapy	80% Allowed Amount after DED	60% of the Allowed Amount after DED
*These Services are subject to the Copayment only.		
Note: 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 web site at www.floridablue.com , contact the local BCBSF office, or review the most recent Provider Directory.		

Other Services

Benefit Description	PPO	Providers Not Participating in PPO
Biofeedback	100% of the Allowed Amount	100% of the Allowed Amount after DED
Colonoscopies (Routine)	100% of the Allowed Amount	60% of the Allowed Amount – DED waived
Independent Clinical Lab	80% of the Allowed Amount	60% of the Allowed Amount
Independent Diagnostic Testing Facility		
Diagnostic Lab and X-ray	\$35 Copayment per visit*	60% of the Allowed Amount after DED
Diagnostic Testing including MRI,CT Scans, Endoscopy and Stress Tests	\$35 Copayment per visit*	60% of the Allowed Amount after DED
Outpatient Hospital		
Diagnostic Lab and X-ray at Hospital	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Diagnostic Testing at Hospital including MRI,CT Scans, Endoscopy and Stress Tests	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Outpatient Private Duty Nursing	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
TMJ Services Note: Limited to 18 visits per BP	100% of the Allowed Amount	100% of the Allowed Amount after DED
Spinal Manipulations	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
*These Services are subject to the Copayment only.		

Behavioral Health Services

Benefit Description	PPO	Providers Not Participating in PPO
<p>Mental Health and Substance Dependency Care and Treatment Services</p> <p>Outpatient Facility Services rendered at:</p> <ol style="list-style-type: none"> 1. Emergency Room 2. Hospital 3. Physician Services at Hospital and ER 	<p>\$50 Copayment per visit*</p> <p>80% of the Allowed Amount after DED</p> <p>100% of the Allowed Amount</p>	<p>\$50 Copayment per visit</p> <p>60% of the Allowed Amount after DED</p> <p>100% of the Allowed Amount</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <ol style="list-style-type: none"> 1. Family Physicians Office 2. Specialist Office 3. All other locations other than Hospital and ER 	<p>\$20 Copayment per visit*</p> <p>\$35 Copayment per visit*</p> <p>80% of the Allowed Amount after DED</p>	<p>60% of the Allowed Amount after DED</p> <p>60% of the Allowed Amount after DED</p> <p>60% of the Allowed Amount after DED</p>
<p>Inpatient</p> <ol style="list-style-type: none"> 1. Facility Services 2. Physician and other health care professionals licensed to perform such Services 	<p>80% of the Allowed Amount after DED</p> <p>100% of the Allowed Amount</p>	<p>60% of the Allowed Amount after DED</p> <p>100% of the Allowed Amount</p>

Benefit Maximums

Accumulated Total Lifetime Maximum Benefit Per Covered Plan Participant Unlimited

Adult Wellness Per Covered Plan Participant Per BP Unlimited

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, 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 DED, 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 BP \$2,500

Home Health Care Days Per Covered Plan Participant Per BP 30

Hospice (Combined Inpatient, Outpatient and Home)

Per Covered Plan Participant Per Lifetime Unlimited

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies Visits Per Covered

Plan Participant Per BP 60

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

Skilled Nursing Facility Days Per Covered Plan Participant Per BP 90

Spinal Manipulations Visits Per Covered Plan Participant Per BP 26

TMJ Visits Per Covered Plan Participant Per BP 18

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 by BCBSF to the Group, amounts applied to a Covered Plan Participant’s Benefit Period benefit maximums under the prior BCBSF policy, will be applied toward the Covered Plan Participant’s Benefit Period benefit maximums under the Evidence of Coverage.

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 Preferred Patient Care (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.

Prescription Drug Program

The Group may have purchased optional pharmacy coverage from BCBSF. If so, please refer to the pharmacy program Endorsement issued to the Group.