

BlueCare

For Large Groups Health Benefit Summary Plan 16



When you enroll in a BlueCare health plan, you will choose a Health Options contracting Primary Care Physician to help coordinate your overall health care.

Benefits

Cost to You

Physician Office Services

Primary Care Physician office services	\$15 copay per visit
Contracting Specialist office services	\$45 copay per visit
Visit to contracting GYN for well-woman exam	\$45 copay per visit

These office services may include:

- Pediatric and well-baby care
- Periodic health evaluation and immunizations
- Other diagnostic services
- Health education
- Professional counseling (family planning, nutritional, and medical social services)
- Vision and hearing screening
- Family planning services
- In-office surgery

Additional Services (Office or Outpatient Facility)

Allergy testing	No copay
Allergy injection, including serum	\$5 copay per visit
Outpatient physical, speech, cardiac and occupational therapies	\$5 copay per visit
Diagnostic lab and X-ray	No copay

Hospital Services (Inpatient Facility)

Room and board	\$300/day for 1-5; Maximum \$1,500/adm.
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These inpatient hospital services may include:

- Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications
- Intensive Care Unit and other special units
- Laboratory and X-ray services
- Inpatient physical, speech, cardiac and occupational therapies

Hospital or Ambulatory Surgical Center (Outpatient Facility)

Outpatient and outpatient surgical services may include:	\$300 copay
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications, including:	
▪ Hospital or surgical center	
▪ Surgeon's fees	
▪ Outpatient laboratory, X-ray, and other tests	

Emergency Services (Hospital)

Use of emergency rooms and emergency services at contracting hospitals	\$100 copay per visit
Use of emergency rooms and emergency services outside of service area or at non-contracting hospitals	\$100 copay per visit

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Benefits

Maternity Services

Primary Care Physician office services

Contracting Specialist office services – initial OB visit only

Certified Nurse Midwife or Midwife

Inpatient hospital services

Birth center services

Behavioral Health Services

Mental Health Care/Substance Dependency

Inpatient Hospitalization Facility Services (per admit)

In-Network

Out-of-Network

Outpatient Hospitalization Facility Service (per visit)

In-Network

Out-of-Network

Emergency Room Facility Services (per visit)

In-Network and Out-of-Network

Provider Services at Hospital and ER

In-Network Family Physician/Specialist

Out-of-Network

Provider Services at Locations other than Hospital or ER

In-Network Family Physician/Specialist

Out-of-Network

Outpatient Office Visit

In-Network Specialist MH/SA

Out-of-Network

Infertility Services

Primary Care Physician

Contracting Specialist

Special Services

Hospice care

Skilled nursing facility – 90 days per benefit period

Home health care

Ambulance (medically necessary)

Durable medical equipment

Prosthetics and orthotics

Maximum Out-of-Pocket

Cost to You

\$15 copay

\$45 copay

No copay

\$300/day for 1-5;

Maximum \$1,500/adm.

No copay

\$300

Not Covered

\$300

Not Covered

\$100

\$0

\$0

\$0

Not Covered

\$50/\$35

Not Covered

\$15 copay per visit

\$45 copay per visit

No copay

No copay

No copay

No copay

No copay

No copay

\$1,500 per Member

\$3,000 per family

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Pre-existing Conditions Limitation

Applies for those not having prior creditable coverage at initial enrollment; group size determines pre-existing conditions limitation. Please refer to the Master Policy for details.

Select Exclusions and Limitations

The following is a partial listing of services that are excluded from coverage under the Master Policy. For a complete listing please refer to the Master Policy.

- All services not specifically listed in the Covered Services section of your Member Handbook or in any rider or endorsement, unless such services are specifically required by state or federal law
- Elective cosmetic surgery
- Hearing aids or eyeglasses, dental care, or oral appliances
- Physical for insurance, licensing, school or recreational purposes
- Elective abortions
- Workers' compensation
- Prescription drugs (unless included through BlueCare Rx)
- Complementary and Alternative Healing Methods (CAM)

The copayments are the responsibility of the Member and must be paid to the provider at the time service is rendered.

Prescription Drug Program

Generic	\$10
Brand	\$30
Non-Preferred	\$45

Mail Order

Generic	\$20
Brand	\$60
Non-Preferred	\$90

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

Referrals to participating providers are not required, however authorizations are required for certain medical services like hospitalization, rehabilitation services, home care, select DME, and certain office based services such as CT scans, MRIs/MRAs, cardiac nuclear medicine studies, and select injectables, etc. Additional information related to access to providers can be found in the Provider Directory. This summary is only a partial description of the many benefits and services covered by Health Options, the HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. These benefits apply only to groups of 51 or more employees. Health Options, Inc. and Blue Cross and Blue Shield of Florida, Inc. are independent licensees of the Blue Cross and Blue Shield Association. This does not constitute a contract. For a complete description of benefits and exclusions, please see Master Policy 86002; its terms prevail.