BlueCare Plan 55		BlueCare HMO 1 Non-Grandfathered Plan Participating Providers
PLAN FEATURES		**Member Expenses**
Calendar Year Deductible	Per Member	$0
	Family Maximum	$0
Member Coinsurance		Covered 100%
Out Of Pocket Maximum (includes deductible and co-pays)	Per Member	$3,000
	Family Maximum	$6,000
Lifetime Maximum		Unlimited except where otherwise indicated.
PREVENTIVE CARE by PCP		
Routine Adult Physical Exams /Immunizations		Eligible expenses covered 100%
Routine Well Child Exams /Immunizations		Eligible expenses covered 100%
Routine GYN Exams		Eligible expenses covered 100%
Routine Mammograms		Eligible expenses covered 100%
PHYSICIAN SERVICES		
PCP Office Visit		$25 co-pay
Specialist Office Visit		$45 co-pay
Chiropractor Office Visit		$45 co-pay
Allergy Injection Office Services (including serum)		$5 co-pay
DIAGNOSTIC PROCEDURES		
Office Visit Diagnostic X -rays & Services		$25 co-pay (PCP); $45 co-pay (Specialist)
Office Visit Diagnostic Advanced Imaging Services (AIS)		$150 co-pay
Free Standing Facility Diagnostic X-rays – (excluding Advanced Imaging Service (AIS))		$45 co-pay
Free Standing Facility Diagnostic Advanced Imaging Services (AIS)		$150 co-pay
Independent Clinical Lab Services		$0 co-pay
Allergy Testing Office Services		$0 co-pay
EMERGENCY MEDICAL CARE		
Urgent Care Provider		$75 co-pay
Emergency Room		$150 co-pay
Ambulance		Covered 100%
HOSPITAL CARE		
Inpatient Hospital		$300 co-pay per day/$1,500 per admit max
Outpatient Hospital (separate co-pays for outpatient therapy may apply)		$150 co-pay
Outpatient Hospital Cardiac, Occupational, Physical & Speech Therapy		$25 co-pay
Birthing Center Services		$150 co-pay
Ambulatory Surgical Facility		$150 co-pay
OTHER SERVICES		
Home Health Care		Covered 100%
Durable Medical Equipment		Covered 100%
PHARMACY		
Retail (up to a 30 day supply)		$15/$35/$60 co-pays
Mail Order (up to a 90 day supply)		$30/$70/$120 co-pays

Due to mental health parity requirements, some claims submitted with a mental health or substance abuse diagnosis may be covered at a higher level of benefits than what is outlined on this summary. For specific details on mental health and/or substance abuse benefit differentials please contact Florida Blue or refer to the COC.

For a complete listing of services that are excluded from the coverage under this plan please refer to the Member Handbook. The co-payments are the responsibility of the Member and must be paid to the provider at the time service is rendered.

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An estimated metal level value for this plan is PLATINUM.

BlueChoice Plan 0702		BlueChoice PPO 1 Non-Grandfathered Plan	
		Participating Providers	**Non-Participating Providers**
PLAN FEATURES		**Member Expenses**	**Member Expenses**
Calendar Year Deductible	Per Member	$500	$2,000
	Family Maximum	$1,500	$6,000
Hospital Per Admission Deductible		$250	$500
Member Coinsurance		10% (after deductible)	40% (after deductible)
Out Of Pocket Maximum (includes deductible and co-pays)	Per Member	$3,000	$4,000
	Family Maximum	$9,000	$12,000
Lifetime Maximum		Unlimited except where otherwise indicated	
PREVENTIVE CARE			
Routine Adult Physical Exams /Immunizations		Eligible expenses covered 100%	40%
Routine Well Child Exams /Immunizations		Eligible expenses covered 100%	40%
Routine GYN Exams		Eligible expenses covered 100%	40%
Routine Mammograms		Eligible expenses covered 100%	
PHYSICIAN SERVICES			
Family Physician Office Visit		$25 co-pay	40% (after deductible)
Specialist Office Visit		$40 co-pay	40% (after deductible)
Chiropractor Office Visit		$40 co-pay	40% (after deductible)
Allergy Injection Office Services (including serum)		$5 co-pay	40% (after deductible)
DIAGNOSTIC PROCEDURES			
Office Visit Diagnostic X -rays & Services		$25 co-pay FP/$40 co-pay Specialist	40% (after deductible)
Office Visit Diagnostic Advanced Imaging Services (AIS)		$150 co-pay	40% (after deductible)
Free Standing Facility Diagnostic X-rays – (excluding Advanced Imaging Service (AIS))		$40 co-pay	40% (after deductible)
Free Standing Facility Diagnostic Advanced Imaging Services (AIS)		$150 co-pay	40% (after deductible)
Independent Clinical Lab Services		10%, deductible waived	40%, deductible waived
Allergy Testing Office Services		$40 co-pay	40% (after deductible)
EMERGENCY MEDICAL CARE			
Urgent Care Provider		$75 co-pay	40% (after deductible)
Emergency Room		10% (after participating provider deductible) plus $150 ER co-pay	
Ambulance		10% (after participating provider deductible)	
HOSPITAL CARE			
Inpatient Hospital	Facility Charges*	10% (after deductible) plus per admission deductible	40% (after deductible) plus per admission deductible
	Provider Charges	10% (after participating provider deductible)	
Outpatient Hospital (separate co-pays for outpatient therapy may apply)	Facility Charges	10% (after deductible)	40% (after deductible)
	Provider Charges	10% (after participating provider deductible)	
Outpatient Hospital Cardiac, Occupational, Physical & Speech Therapy		10% (after deductible)	40% (after deductible)
Birthing Center Services		10% (after deductible)	40% (after deductible)
Ambulatory Surgical Facility		10% (after deductible)	40% (after deductible)
OTHER SERVICES			
Home Health Care		10% (after deductible)	40% (after deductible)
Durable Medical Equipment		10% (after deductible)	40% (after deductible)
PHARMACY			
Retail (up to 30 day supply)		$15/$35/$60 co-pay	50%
Mail Order (up to 90 day supply)		$30/$70/$120 co-pay	50%

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An estimated metal level value for this plan is PLATINUM.

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BlueOptions Plan 03559		BlueOptions PPO 1 Non-Grandfathered Plan	
		Participating Providers	**Non-Participating Providers**
PLAN FEATURES		**Member Expenses**	**Member Expenses**
Calendar Year Deductible	Per Member	$500	$2,000
	Family Maximum	$1,500	$6,000
Member Coinsurance		10% (after deductible)	40% (after deductible)
Out Of Pocket Maximum (includes deductible and co-pays)	Per Member	$2,500	$6,000
	Family Maximum	$7,500	$18,000
Lifetime Maximum		Unlimited except where otherwise indicated	
PREVENTIVE CARE			
Routine Adult Physical Exams /Immunizations		Eligible expenses covered 100%	40%
Routine Well Child Exams /Immunizations		Eligible expenses covered 100%	40%
Routine GYN Exams		Eligible expenses covered 100%	40%
Routine Mammograms		Eligible expenses covered 100%	
PHYSICIAN SERVICES			
Family Physician Office Visit		$25 co-pay	40% (after deductible)
Specialist Office Visit		$40 co-pay	40% (after deductible)
Chiropractor Office Visit		$40 co-pay	40% (after deductible)
Allergy Injection Office Services (including serum)		$10 co-pay	40% (after deductible)
DIAGNOSTIC PROCEDURES			
Office Visit Diagnostic X -rays & Services		$25 co-pay FP/$40 co-pay Specialist	40% (after deductible)
Office Visit Diagnostic Advanced Imaging Services (AIS)		$150 co-pay	40% (after deductible)
Free Standing Facility Diagnostic X-rays – (excluding Advanced Imaging Service (AIS))		$50 co-pay	40% (after deductible)
Free Standing Facility Diagnostic Advanced Imaging Services (AIS)		$150 co-pay	40% (after deductible)
Independent Clinical Lab Services		$0 co-pay	40% (after deductible)
Allergy Testing Office Services		$40 co-pay	40% (after deductible)
EMERGENCY MEDICAL CARE			
Urgent Care Provider		$75 co-pay	40% (after deductible)
Emergency Room		10% (after participating provider deductible) plus $100 ER co-pay	
Ambulance		10% (after participating provider deductible)	
HOSPITAL CARE			
Inpatient Hospital	Facility Charges	Per admit co-pay of $1,000 (option 1) or $1,500 (option 2)	40% (after deductible)
	Provider Charges	10% (after participating provider deductible)	
Outpatient Hospital (separate co-pays for outpatient therapy may apply)	Facility Charges	Per admit co-pay of $200 (option 1) or $300 (option 2)	40% (after deductible)
	Provider Charges	10% (after participating provider deductible)	
Outpatient Hospital Cardiac, Occupational, Physical & Speech Therapy		$45 co-pay (option 1)/$60 co-pay (option 2)	40% (after deductible)
Birthing Center Services		10% (after deductible)	40% (after deductible)
Ambulatory Surgical Facility		$100 co-pay	40% (after deductible)
OTHER SERVICES			
Home Health Care		10% (after deductible)	40% (after deductible)
Durable Medical Equipment		10% (after deductible)	40% (after deductible)
PHARMACY			
Retail (up to 30 day supply)		$15/$35/$60 co-pay	50%
Mail Order (up to 90 day supply)		$30/$70/$120 co-pay	50%

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