

# Know Before You Go

## BlueCare Plan 1477AP

**\$** See inside for more ways to save and stay healthy!

Your plan includes all these services at **NO COST**:

- \$0** Routine physicals, immunizations, well-child visits and more
- \$0** Lab tests and blood work at Quest Diagnostics
- \$0** Generic oral contraceptives and mail order generic drugs for depression, diabetes, asthma, high blood pressure and cholesterol
- \$0** Eye exams, lenses and more for children under age 19
- \$0** Dental cleanings, fillings and more for children under age 19

Plus much more:

- \$4 Generic drugs available at your local pharmacy
- A nurseline for health questions 24/7 — call 1-877-789-2583<sup>1</sup>
- Health programs for heart disease, diabetes, asthma and more

**TIP:** Using these benefits won't raise the cost of your health plan. You **must use in-network providers** for the lowest cost (except in an emergency). For routine preventive services at \$0, tell the doctor's office to write "wellness exam" on the claim.

## We are here to help!

As a member, you can talk to us or go online for answers about the quality and cost of your care, doctors in our networks and more — we can help you save time and money.

- Call** 1-888-476-2227 about benefits or treatment costs
- Click** [floridablue.com](http://floridablue.com) and log in to your member account
- Visit** a Florida Blue Center – find one near you at [floridablue.com](http://floridablue.com)



## How Your Health Plan Works

What you pay for covered services is based on an "allowed amount." This is a lower cost we have negotiated with in-network providers.

### Copay

For some health care services you'll pay a flat fee, usually at the time you receive the care.



### Deductible

The dollar amount that you must pay each year before we begin to pay for certain health care services. You pay the plan deductible first, then coinsurance (%) may apply.

#### In-network

\$4,000 per person  
\$9,000 per family

#### Out-of-network

Not covered

### Coinsurance (%)

The percentage (%) you may pay for services **after** you meet the deductible.

#### In-network

10% of the allowed amount

#### Out-of-network

Not covered



### Out-of-Pocket Maximum

This is the most you pay for covered health care services during your plan's calendar year. All of your covered expenses go toward this maximum. Once you reach the maximum, your plan pays 100% for covered services.

#### In-network

\$5,200 per person  
\$10,400 per family

#### Out-of-network

Not covered

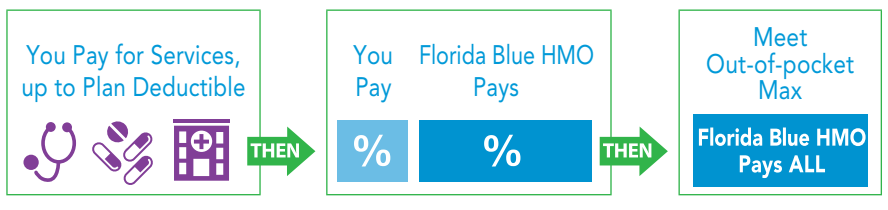
**Important:** To ensure quality care and to help you get the most value from your plan benefits, **you need to get an approval** from Florida Blue HMO for certain services before your appointment or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit [floridablue.com/Authorization](http://floridablue.com/Authorization) or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps. Other services **that require your participating provider to obtain an approval** can include: behavioral health services, hospitalization, rehabilitation services, home care, select DME and cardiac nuclear medicine studies, etc.

A health maintenance organization plan  
**BlueCare Everyday Health Plus Plan 1477AP (Silver)**



76691-0813

## \$ How the Deductible Works for Covered Services



## 👤 What You'll Pay In-network

**Costs shown are for in-network providers.** BlueCare is one of our networks made up of independent contracted hospitals, physicians and ancillary providers who are considered in-network for your BlueCare health plan. Out-of-network services are not covered (except for emergency services).

**TIP:** Choose your Primary Care Physician (PCP) when you enroll, or we'll choose one for you. You can easily change your PCP at any time, or find other network providers, by logging in to your account at [floridablue.com](http://floridablue.com).

Health Services	Where to go for your services	What you pay in-network
Office Services	Blue Physician Recognition Primary Care Physician	\$70 Copay
	Primary Care Physician	\$70 Copay
	Convenient Care Center	\$70 Copay
	Specialist	10% after Deductible
	Urgent Care Center	10% after Deductible

**TIP:** The Blue Physician Recognition (BPR) designation means the physician has demonstrated a commitment to delivering quality and patient-centered care by participating in one of the following Florida Blue HMO programs: Patient Centered Medical Home (PCMH), Comprehensive Primary Care (CP2) or an Accountable Care arrangement. The BPR designation does not serve as a measure of the quality of care provided by a physician or whether the physician will meet your particular healthcare needs. Absence of a BPR icon does not mean the physician is of low quality. It simply means that the physician does not participate in one of these programs.

Health Services	Where to go for your services	What you pay in-network
Drugs Administered in the Office <i>Cost applies to the drug only and is in addition to the cost of the office visit</i>	Physician's Office Paid at 100% for the rest of the calendar month once out-of-pocket maximum is paid	\$60 Copay Up to the monthly out-of-pocket maximum: \$240
Lab Services (blood work)	Quest Diagnostics Clinical Lab	\$0
Emergency	Urgent Care Center	10% after Deductible
	Hospital	10% after Deductible
<b>TIP:</b> For non-emergency care, a Convenient Care or Urgent Care Center should be able to provide services at a lower cost.		
Hospital and Surgical Facilities and Providers	Ambulatory Surgical Center Provider/Surgeon Fee	10% after Deductible \$0
	Outpatient Hospital Provider/Surgeon Fee	10% after Deductible \$0
	Inpatient Hospital Provider/Surgeon Fee	10% after Deductible \$0
Basic Imaging (X-ray, Ultrasound, etc.)	Primary Care Physician	\$70 Copay
	Specialist	10% after Deductible
	Independent Imaging Facility (IDTC)	10% after Deductible
	Outpatient Hospital	10% after Deductible
Advanced Imaging (MRI, MRA, CT, PET, Nuclear Medicine)	Independent Imaging Facility (IDTC)	10% after Deductible
	Primary Care Physician, Specialist	10% after Deductible
	Outpatient Hospital	10% after Deductible

**TIP:** What you'll pay for imaging can be very different depending on where you go. Call, click or visit us for cost estimates before you go.

## What You'll Pay In-network (continued)

Health Services	Where to go for your services	What you pay in-network
Rehabilitative Services	Outpatient Rehabilitation Facility	10% after Deductible
	Outpatient Hospital	10% after Deductible
Habilitative Services	Outpatient Rehabilitation Facility	10% after Deductible
	Outpatient Hospital	10% after Deductible
Outpatient Therapy and Spinal Manipulation	Primary Care Physician	\$70 Copay
	Specialist	10% after Deductible
	Outpatient Rehabilitation Facility	10% after Deductible
	Outpatient Hospital	10% after Deductible
Your plan offers 35 visits per person per calendar year. This includes any combination of Outpatient Cardiac Rehabilitation, Occupational, Physical, Speech and Massage Therapies, and Spinal Manipulations/Chiropractor visits.		
Mental Health and/or Substance Dependency Services	Outpatient Office Visit	10% after Deductible
	Inpatient Hospital Facility Services	10% after Deductible
<b>TIP:</b> Call 1-866-287-9569 for coordination of all behavioral health care.		

Health Services	What you pay in-network
<b>Pediatric Vision Care</b> (under age 19)	<b>Where to go for your services: Only in-network</b> optometrists, ophthalmologists and retail providers.
Exam	\$0
Eyeglass Lenses	\$0
Frames	<u>Pediatric Selection:</u> \$0 <u>Non-Selection:</u> Amount over standard \$150 allowance, minus a 20% discount (No discount at Sam's/Walmart)
Contact Lenses (Instead of eyeglasses)	Amount over standard \$150 allowance, minus a 15% discount (No discount at Sam's/Walmart)
Includes contact lenses, evaluation, fitting and follow up care.	
Note: Anything over the allowance will not go toward your out-of-pocket maximum.	
<b>Pediatric Dental Care</b> (under age 19)	<b>Where to go for your services: Only in-network</b> general dentists and specialists
Preventive, basic and major	\$0

**\$ Know Before You Go** Before you get health services, we can help you **compare quality and cost** to make sure you're getting the best care at the best price. Log in to your member account, call us, or visit your local Florida Blue Center to know before you go.

Medical Treatment or Surgery	Quality	Cost
In-network Surgical Center	★ ★ ★	
In-network Hospital A	★ ★ ★	
Out-of-network Hospital B	★ ★ ★	

## What You'll Pay In-network for Covered Drugs

BlueCare Rx® Pharmacy Program Drug Tiers	What you pay in-network Retail Pharmacy (1 month supply)	What you pay in-network Mail Order (3 month supply)
<b>Generic Drugs - Tier 1</b>		
Preventive (e.g., oral contraceptives)	\$0	\$0
Condition Care Rx (high blood pressure, cholesterol, diabetes, depression, asthma)	\$4 Copay	\$0
All other Generics	\$15 Copay	\$38 Copay
<b>Brand Drugs - Tier 2</b>		
Condition Care Rx (high blood pressure, cholesterol, diabetes, depression, asthma)	\$30 Copay	\$75 Copay
All other Preferred Brand Drugs	\$60 Copay	\$150 Copay
<b>Non-Preferred Brand Drugs - Tier 3</b>		
Non-preferred Brand Drugs	\$100 Copay	\$250 Copay
<b>Specialty Drugs - Tier 4</b>		
Specialty Drugs purchased from a Specialty Pharmacy	\$150 Copay	Not covered

*Certain vaccines covered by Wellness Benefits can be given by Pharmacists who are certified.*

**TIP:** Be sure to know before you go fill your prescription. Check the [Medication Guide](#) at [floridablue.com](#) or call us to find out how a drug is covered, and if it requires that your doctor requests an authorization or that you try another drug first.

 **Know Before You Go** Find the lowest drug prices: log in to your member account at [floridablue.com](#) to **shop and compare** drug prices at nearby pharmacies. **Generics: Just as Effective and Cost Less**



Generic



Brand



Non-Preferred Brand



## Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the BlueCare Contract.

- All services not specifically listed in the Contract or endorsement, unless such services are specifically required by state law
- Any service not Medically Necessary
- Elective cosmetic surgery
- Hearing aids
- Eyeglasses, vision or dental care, or oral appliances for adults age 19 and over
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care (except treatment for diabetic foot disease)

The policy has limitations and exclusions. The amount of benefits provided depends on the plan selected and the premium may vary with the amount of benefits selected. This document is only a partial description of the many benefits and services provided or authorized by Florida Blue HMO and it does not constitute a contract. Florida Blue HMO members should look at their BlueCare contract for a complete description of benefits and exclusions.

Go to [floridablue.com](#) and click on **Find a Doctor and More** to easily find a doctor in your plan's network. You don't need a referral to see a participating provider.

**How to Appeal an Adverse Benefit Determination or a Grievance:** You have the right to appeal an Adverse Benefit Determination or file a Grievance with us. Your appeal or grievance will be reviewed using the review process described in your contract. It must be submitted to us in writing for an internal appeal within 365 days of the adverse benefit determination. But if it's a Concurrent Care Decision, it may require you to file within a shorter period of time from notice of the denial.

<sup>1</sup>As a courtesy, Florida Blue HMO has entered into an arrangement with Health Dialog to provide this service. Florida Blue HMO has not certified or credentialed, and cannot guarantee or be held responsible for, the quality of services provided by this vendor.

*Florida Blue HMO is a trade name of Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.*