BlueChoice

For Individuals Under 65

Benefit Summary Plan 2

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

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With the BlueChoice PPO Plan, you have the freedom to get care from your PPO network Family Physician, or other providers of care as you see fit. In order to take advantage of lower out-of-pocket costs, simply choose a PPO Family Physician who specializes in Family Practice, General Practice, Internal Medicine or Pediatrics.

Benefits

Financial Responsibilities for Covered Services

Deductible

Individual Calendar Year Deductible Options Available . . . . $750, $1,500 or $2,500

Hospital Per Admission Deductible

- PPO Hospitals $0
- Hospitals Not Participating In PPO $500

Note: The Hospital Per Admission Deductible is in addition to the Calendar Year Deductible.

Coinsurance Percentage Payable by BCBSF

PPO Providers—Allowed Amount 70%

Providers Not Participating In PPO—Allowance 50%

- Ambulance Services—Allowance 70%

Your Coinsurance Responsibility per Calendar Year

Individual Coinsurance Limit . . . . $4,000, $5,000 or $6,000

Family Coinsurance Limit . . . . $8,000, $10,000 or $12,000

Office Services

PPO Family Physician:

- Office services by a PPO Family Physician (Copayment only) $20
- Allergy Injections per visit (Copayment only) $5
- Durable Medical Equipment, Prosthetics and Orthotics are always subject to the Calendar Year Deductible and Coinsurance; no Copayment applies

All Other Providers

- Office services provided by any provider other than a PPO Family Physician are subject to the Calendar Year Deductible and Coinsurance; no Copayment applies

Prescription Drugs

Retail Pharmacy Program

- Generic drugs paid at 80% of the Participating Pharmacy Allowance
- Brand name paid at 60% of the Participating Pharmacy Allowance

Maximum benefit per Calendar Year . . . . $500 per insured

Oral Contraceptives and Devices are excluded from coverage.

Benefit Maximums

Calendar Year Maximums per Insured

Mental Health Services Benefit Maximum:
- Inpatient $1,000
- Outpatient $300

Home Health Care Benefit Maximum $2,500
Skilled Nursing Facility Days Benefit Maximum 60
Enteral Formula (Low Protein Food Products) Benefit Maximum $2,500
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Benefit Maximum $1,500
Adult Wellness Benefit Maximum per Insured per Calendar Year $150

Covered Services for an adult (i.e., age 17 and older)
Includes the following:
- Annual physical or gynecological exam
- Related wellness services (e.g., Pap smears, Prostate Specific Antigen [PSA], X-rays, laboratory services, and immunizations). Routine vision and hearing examinations and screenings are not covered.

Because we want to make sure you take advantage of these great benefits, adult wellness services are not subject to the Individual Calendar Year Deductible. You'll only need to meet the Copayment, or applicable Coinsurance, depending on where you receive care and the participating status of your chosen Provider.

Lifetime Maximums per Insured

Total Lifetime Maximum Benefit $2,000,000
Substance Dependency Care and Treatment Benefit Maximum $2,000
Hospice Benefit Maximum $5,200
Mental and Nervous $5,000

Additional Benefits and Features

Accident Care

Covered Services in connection with an Accident are not subject to the Individual Calendar Year Deductible. All other Insured's financial responsibilities, including the Hospital per Admission Deductible, Coinsurance, and Copayment (if applicable) will continue to apply.

Select Exclusions and Limitations

The following is a partial listing of services that are excluded from coverage under the Individual BlueChoice Contract. For a complete listing, please refer to the Contract.

- All services not specifically listed in the Contract or in any rider or endorsement, unless such services are specifically required by state law
- Any service which is not Medically Necessary
- Maternity care
- Elective cosmetic surgery
- Hearing aids or eyeglasses, vision or dental care, or oral appliances
- Elective abortions
- Infertility services
- Work-related Condition services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care
- Oral Contraceptives and Devices

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual Contract for details.

This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. This does not constitute a Contract. For a complete description of benefits and exclusions, please see your Contract.

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