

Miami-Dade Blue

For Individuals Under 65

Benefit Summary Plan 01



Benefits for Covered Services

Amount Member Pays

<p>This Miami-Dade Blue Plan provides you with routine health care services, such as physician office services, as well as basic protection against major illnesses requiring hospitalization or surgery. We encourage you to carefully review what the plan covers and understand what your out-of-pocket costs may be.</p>		<h2>Plan 01</h2>
<h4>Office Services</h4>		
<p>Physician Office Services (Includes routine check-ups, allergy injections in-office surgery, and e-office visits)</p>	<p>In-Network: We pay \$50 or the Allowed Amount¹ (whichever is lower) and the member pays the balance² up to Allowed Amount</p> <p>Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge</p>	
<h4>Preventive Care</h4>		
<p>Adult Wellness Benefit Maximum</p>	None	
<p>Routine Adult Physical Exam and Immunizations</p>	<p>In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount</p> <p>Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge</p>	
<p>Well Woman Exam (e.g. Annual GYN)</p>	<p>In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount</p> <p>Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge</p>	
<p>Mammograms In-Network Out-of-Network</p>	<p>\$0 40% of Allowed Amount + the balance of provider's charges</p>	
<p>Well Child (No PBP³ max)</p>	<p>In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount</p> <p>Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge</p>	

¹ The Allowed Amount is the amount we have negotiated with providers for payment of covered services, instead of a member paying the full charge for a service.

² "Balance" is the difference between our payment and the amount an In-Network provider agrees to accept as payment in full for covered services (the allowed amount). For Out-of-Network providers, "balance" is the difference between our payment (allowed amount) and the provider's charge. You are responsible for paying the doctor or provider this "balance".

³ PBP = Per Benefit Period

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Prescription Drug Program (BlueScript)	
Pharmacy Deductible	\$0
Generic / Brand / Non-Preferred	\$10 Copayment / Discount Only*
Mail Order (90-day supply) Generic / Brand / Non-preferred	Not Covered
<p>BlueScript Pharmacy benefit also provides coverage for prescription oral contraceptives, prescription diaphragms and diabetic equipment and supplies. *Brand or Non-Preferred drugs are not covered under this plan. However you can take advantage of the negotiated discounts at participating pharmacies for most Brand and Non-Preferred drugs. You will be responsible for the entire cost of these drugs at the discounted price. The BlueSaver savings program can also provide you with special discounted pricing on brand name prescription drug purchases not available under your BlueScript plan (such as smoking cessation drugs) when you show your BlueSaver ID card at participating pharmacies. The BlueSaver savings program is administered by Medical Security Card Company (MSC) of Tucson, Arizona and is not an insurance product.</p>	
Emergency Medical Care	
Urgent Care Centers	<p>In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount</p> <p>Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge</p>
<p>Emergency Room Facility Services (ER) (per visit) If Admitted or if a surgical service is performed</p> <p>In-Network Out-of-Network</p> <p>Non-Surgical Services Per Visit Deductible (PVD) In-Network Out-of-Network</p>	<p>DED⁴ + 10% of Allowed Amount DED + 10% of Allowed Amount + balance of provider's charges</p> <p>\$500 PVD + DED + 10% of Allowed Amount PVD + DED + 10% of Allowed Amount + balance of provider's charges</p>
<p>Ambulance Services (Ground travel / Air and water travel, per day maximum)</p> <p>In-Network Out-of-Network</p>	<p>\$5,000 DED + 10% of Allowed Amount DED + 10% of Allowed Amount + balance of provider's charges</p>
Outpatient Diagnostic Services	
<p>Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)</p> <p>In-Network Out-of-Network</p>	<p>\$75 Copayment DED + 40% of Allowed Amount + the balance of provider's charges</p>
<p>Independent Clinical Lab (e.g. Blood Work)</p> <p>In-Network Out-of-Network</p>	<p>\$0 DED + 40% of Allowed Amount + balance of provider's charges</p>
<p>Outpatient Hospital Facility Services (per visit) (Surgical Services Only) (e.g. Surgeries, proximately related Blood Work and X-rays)</p> <p>In-Network Out-of-Network</p>	<p>DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges</p>

⁴ DED = Deductible—The amount, if any, per calendar year, you owe before we begin to pay for covered services.

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Mental Health/Substance Dependency	
Mental Health (Inpatient PBP / Outpatient PBP) Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit	8 Days / 8 Visits DED + 10% of Allowed Amount \$500 PAD + DED + 40% of Allowed Amount + balance of provider's charges In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge
Substance Dependency Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network Per Admission Deductible (PAD) Out-of-Network Outpatient Office Visit	DED + 10% of Allowed Amount \$500 PAD + DED + 40% of Allowed Amount + balance of provider's charges In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge
Other Provider Services	
Provider Services at Hospital and ER If Admitted or if a surgical service is performed In-Network Out-of-Network Non-Surgical Services at ER Per Visit Deductible (PVD) In-Network Out-of-Network	DED + 10% of Allowed Amount INN DED + 10% of Allowed Amount + balance of provider's charges \$500 PVD + DED + 10% of Allowed Amount PVD + INN DED + 10% of Allowed Amount + balance of provider's charges
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network Out-of-Network	DED + 10% of Allowed Amount INN DED + 10% of Allowed Amount + balance of provider's charges
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / In-Network Specialist Out-of-Network	DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges

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Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP max) In-Network locations other than Hospital and Physician Office (e.g., PT Clinic) Out-of-Network locations other than Hospital and Physician Office Outpatient Hospital Facility	25 Visits DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges Not Covered
Durable Medical Equipment (If proximately related to surgery, Inpatient Admissions or ER services only) In-Network Out-of-Network	DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Home Health Care (PBP max) In-Network Out-of-Network	45 Visits DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Skilled Nursing Facility (PBP max) In-Network Out-of-Network	45 Days DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Hospice In-Network Out-of-Network	DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) (Surgical Services Only) In-Network Out-of-Network	DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Inpatient Hospital Facility and Rehabilitation Services (per admit) In-Network Out-of-Network Per Admission Deductible (PAD) Out-of-Network	Rehabilitation Services limit - 21 days PBP DED + 10% of Allowed Amount \$500 PAD + DED + 40% of Allowed Amount + balance of provider's charges
Outpatient Hospital Facility Services (per visit) (Surgical Services Only) In-Network Out-of-Network	DED + 10% of Allowed Amount DED + 40% of Allowed Amount + balance of provider's charges
Emergency Room Facility Services (per visit) If Admitted or if a surgical service is performed In-Network Out-of-Network Non-Surgical Services Per Visit Deductible (PVD) In-Network Out-of-Network	DED + 10% of Allowed Amount DED + 10% of Allowed Amount + balance of provider's charges \$500 PVD + DED + 10% of Allowed Amount PVD + DED + 10% of Allowed Amount + balance of provider's charges
Dental Coverage	
Preventive and Routine Dental Services Includes coverage for services such as routine oral exams and cleanings 2 times/yr, bitewing x-rays once/yr, and fluoride for children 2 times/yr., fillings and denture repairs.	In-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount Out-of-Network: We pay \$50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge

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Financial Features	
Deductible (per person / family aggregate) In-Network Out-of-Network Deductible (DED) is the amount the member is responsible for before BCBSF pays	\$250 / NA \$750 / NA
Per Admission Deductible (PAD) (Out-of-Network Inpatient Hospital Facility Services)	\$500
Emergency Room Non-Surgical Per Visit Deductible (PVD) (Facility and Physician Services)	\$500
Coinsurance (Member pays) In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	You pay 10% of the Allowed Amount You pay 40% of the Allowed Amount + the balance of provider's charge
Out-of-Pocket Maximum (per person / family aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance, Copays and PAD; excludes Prescription Drugs, Emergency Room PVD, and the balance after \$50 BCBSF maximum payment)	\$2,500 / NA \$5,000 / NA
Total Lifetime Maximum Benefit	No Maximum

Important information regarding Miami-Dade Blue Coverage

Certain services, such as Advanced Imaging Services, Durable Medical Equipment and Specialty Drugs, require prior authorization before obtaining service. While it is your responsibility to confirm the network participation status of a provider before you receive the service, it is the participating provider's responsibility to obtain the prior authorization. If there is no prior authorization on file, it will result in the claim being denied. If you choose to use a non-participating provider for certain services, such as Advanced Imaging Services, you may have an obligation to ensure an authorization is on file to receive coverage for the service. Please see your Miami-Dade Blue Contract to understand when you may need to take steps to ensure full benefit access.

Limitations and Exclusions

The following is a partial list of services that are excluded from coverage under the Individual Miami-Dade Blue Contract. For a complete description of benefits and exclusions, please see 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 care, or oral appliances
- Elective abortions
- Infertility services
- Complementary and Alternative Healing Methods (CAM)
- Routine foot care

A 24-month pre-existing condition limitation applies to all services. Please refer to the Individual Miami-Dade Blue 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.