| BENEFIT HIGHLIGHTS | IN-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- |
| **Plan Name:** | Florida Blue Plan 47 - HMO |  |
| **MEDICAL** |  |  |
| **Lifetime Maximum** | Unlimited |  |
| **Calendar Year Deductible**  Individual / Family Maximum | $1,500 / $4,500 |  |
| **Out-of-Pocket Maximum**  Individual / Family Maximum | $4,500 / $9,000 |  |
| **Out-of-Pocket Limit**  What is included: | Deductible Coinsurance Copayments  Prescription Drugs |  |
| **Coinsurance** | 20% |  |
| **Medical Pharmacy**  In-Network Monthly OOP  In-Network  Out-of-Network | $200  20% coins  Not Covered |  |
| **Physician’s Services** |  |  |
| Primary Care Visit – Office visits and minor surgical procedures | $30 copay |  |
| Specialist Visit | $55 copay |  |
| Urgent Care | $60 copay |  |
| Independent Clinical Lab Services  **Quest – Exclusive In-Network Provider**  Out-of-Network | $0 | Required Lab Provider? |
| Advanced Imaging Services | $250 copay |  |
| **Preventive Care** |  |  |
| **Per Benefit Period** | Unlimited |  |
| **Adult Wellness Services**  Routine Adult Physical Exams and Immunizations  Family Physician | $0 |  |
| Specialist | $0 |  |
| Mammograms | $0 |  |
| Routine Colonoscopy (50+) | $0 |  |
| **Well Child Care Services**  Family Physician | $0 |  |
| Specialist | $0 |  |
| **Other Types of Facility and Provider Services** | | |
| **Inpatient** | CYD + 20% |  |
| Physician and other health care professional services | CYD + 20% |  |
| **Outpatient**  Facility | CYD + 20% |  |
| Physician and other health care professional services | CYD + 20% |  |
| **Emergency Room Visits**  Facility In/Out-of-Network | $250 copay |  |
| Physician and other health care professional services | CYD + 20% |  |
| **Ambulance – Ground/Air & Water** | CYD + 20% / CYD + 20% |  |
| **Ambulatory Surgical Center Facility Services** | $200 copay |  |
| Radiology, Pathology, Anesthesiology Provider Services at an Ambulatory Surgical Center | Family Physician - $30 copay  Specialist - $55 copay |  |
| **Therapy Services**  Cardiac Rehabilitation, Occupational, Speech, Physical, Massage & Spinal Manipulations  Outpatient Rehab Therapy Center  In-Network  Outpatient Hospital Facility Services (per visit)  In-Network | $55 copay  $55 copay |  |
| Calendar Year Maximums: | 35 visits |  |
| **Home Health Care** | $0 |  |
| Calendar Year Maximum: | 20 visits |  |
| **Skilled Nursing Facility** | CYD + 20% |  |
| Calendar Year Maximum: | 60 days |  |
| **Hospice** | CYD + 20% |  |
| Calendar Year Maximum: | Unlimited |  |
| **Durable Medical Equipment & Prosthetics and Orthotics**  Motorized Wheelchair  All Other | $500 copay  $0 |  |
| **Allergy Injections** | $10 copay |  |
| **Mental Health and Substance Abuse Services** | | |
| **Mental Health and Substance Dependency Care and Treatment Services**  Inpatient / Outpatient  Facility Services | $0 |  |
| Emergency Room | $0 / $0 |  |
| Physician Services at Hospital and ER | $0 |  |
| Physician and Other Health Care Professionals  Family Physician Office | $0 |  |
| Specialist Office | $0 |  |
| **Prescription Drug Benefits** | | |
| **RETAIL – 30 DAY SUPPLY** | | |
| Pharmacy Deductible | $100 – both retail and mail |  |
| Retail Preferred Generic | $20 copay |  |
| Retail Preferred Brand | $50 copay |  |
| Retail Non-Preferred Brand | $80 copay |  |
|  |  |  |
| **MAIL ORDER – 90 DAY SUPPLY** | | |
| Mail Order Generic | $40 Copay |  |
| Mail Order Brand Preferred | $100 Copay |  |
| Mail Order Brand Non-Preferred | $160 Copay |  |