



LEON COUNTY SELECTION SCHEDULE OF COPAYMENTS

COVERED SERVICE	UNIT	COPAYMENT
Physician Office Services		
Office visit for services provided by member's primary care physician or other CHP personnel during regular office hours	Per visit	\$10
Office visit for services provided by primary care physician or other CHP personnel after regular office hours (including evenings and weekends)	Per visit	\$15
Office visit for services provided by participating provider when authorized by primary care physician	Per visit	\$10
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by primary care physician	Per visit	\$10
Mental Health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	By Endorsement Only	
	Per visit	\$10
Hospital Services		
All hospital benefits covered under this agreement	Per admission	\$0
Outpatient procedures performed in a hospital	Per visit	\$0
Mental health inpatient care	By Endorsement Only	
	Per admission	\$0
Maternity Services		
Physician Office Services		
<ul style="list-style-type: none"> Office visit for services provided by a member's primary care physician 	Per visit	\$10
<ul style="list-style-type: none"> Office visit for services provided by participating provider when authorized by the primary care physician non-plan provider when authorized by the Medical Director of CHP 	Per visit	\$10
Hospital Services: All maternity inpatient care	Per admission	\$0

COVERED SERVICE	UNIT	COPAYMENT
Emergency Services		
Emergency room visit	Per visit	\$100 (waived if admitted)
Medically necessary ambulance service	Per transport	\$0
Other Benefits		
Home health services	Per occurrence	\$0
Hospice home care	Per occurrence	\$0
Hospice outpatient care	Per occurrence	\$0
Hospice inpatient care	Per occurrence	\$0
Skilled nursing facility for up to 60 days per admission with subsequent admission available following 180 days from discharge date of previous admission	Per confinement	\$0
Outpatient procedures performed in an ambulatory surgical center	Per visit	\$0
Durable medical equipment	\$2,500 maximum benefit per calendar year	
Orthotic and Prosthetic medical appliances	Per appliance	\$0
Diagnostic Imaging including MRI, PET, and CT Scan	Per scan	\$0
Outpatient prescription drugs	Covered by endorsement only	
Visit for short-term physical/speech or other rehabilitation therapies	Per visit	\$10
Routine eye exam	Per visit	\$10
Exclusions – Copayments not applicable		
<ul style="list-style-type: none"> The maximum amount of copayment required from any member in any contract year is limited to an amount equal to twice the annual Prepayment Fee applicable to each member or contract. The maximum amount of copayment required in any calendar year is limited to \$1500 per member and \$3000 per family, excluding copayments for prescription drugs. It is the member's responsibility to retain receipts and to notify and document to the satisfaction of CHP that the copayment limit has been reached. After that notification and documentation, services will be provided with no copayment charge for the remainder of the contract year. 		

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BlueOptions

For Large Groups
Health Benefit Summary Plan 1551



BlueCross BlueShield
of Florida

An Independent Licensee of the
Blue Cross and Blue Shield Association

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Benefits for Covered Services

Amount Member Pays

Office Services	In-Network	Out of Network
Physician Office Services Family Physician Specialist e-Office Visit	\$15 Copayment \$30 Copayment \$10 Copayment	CYD ¹ +40% Coinsurance CYD + 40% Coinsurance
Maternity Initial Visit Specialist	\$30 Copayment	CYD + 40% Coinsurance
Allergy Injections (rendered by an In-Network Physician)	\$10 Copayment	CYD + 40% Coinsurance
Preventive Care		
Adult Wellness Benefit Maximum (PCY ² max, includes Well Woman and Routine Adult Physical Exam and Immunizations)	\$150	\$150
Routine Adult Physical Exam and Immunizations (Applies towards Adult Wellness PCY max) Family Physician Specialist	\$15 Copayment \$30 Copayment	40% Coinsurance
Well Woman Exam (e.g. Annual GYN) (Applies towards Adult Wellness PCY max) Family Physician Specialist	\$15 Copayment \$30 Copayment	40% Coinsurance
Mammograms (Covered at 100% of Allowed Amount, In- and Out-of-Network)	\$0	\$0
Well Child (No PCY max) Family Physician Specialist	\$15 Copayment \$30 Copayment	40% Coinsurance
Emergency Medical Care		
Urgent Care Centers	\$30 Copayment	CYD + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	\$100 Copayment + 10% Coinsurance	\$100 Copayment + 40% Coinsurance
Ambulance Services (Ground travel / Air and water travel, per day maximum)	CYD + 10% Coinsurance \$400 / \$4,000	CYD + 10% Coinsurance \$400 / \$4,000
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	\$75 Copayment	CYD + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work)	\$0	CYD + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) (Option 1 / Option 2)	\$100 Copayment / \$200 Copayment	\$300 Copayment

1 CYD = Calendar Year Deductible

2 PCY = Per Calendar Year

Note: Out-of-Network services may be subject to balance billing.

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Benefits for Covered Services

Mental Health/Substance Dependency	In-Network	Out-of-Network
Mental Health (PCY) Inpatient Hospital Facility Services (per admit) (Option 1 / Option 2) Outpatient Office Visit Specialist	30 Inpatient days, 20 Outpatient visits \$400 Copayment / \$800 Copayment \$30 Copayment	30 Inpatient days, 20 Outpatient visits \$1,200 Copayment CYD + 40% Coinsurance
Substance Dependency (Lifetime max) Inpatient Hospital Facility Services (per admit) (Option 1 / Option 2) Outpatient Office Visit Specialist	\$2,500 \$400 Copayment / \$800 Copayment \$30 Copayment	\$2,500 \$1,200 Copayment CYD + 40% Coinsurance
Other Provider Services		
Provider Services at Hospital and ER	CYD + 10% Coinsurance	CYD + 10% Coinsurance
Provider Services at Locations other than Office, Hospital and ER Family Physician Specialist	CYD + 10% Coinsurance CYD + 10% Coinsurance	CYD + 40% Coinsurance
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max) Locations other than Hospital and Physician's Office Locations other than Hospital Outpatient Hospital Facility Services (per visit) (Option 1 / Option 2)	\$2,500 \$30 Copayment \$100 Copayment / \$200 Copayment	\$2,500 CYD + 40% Coinsurance \$300 Copayment
Durable Medical Equipment	CYD + 10% Coinsurance	CYD + 40% Coinsurance
Home Health Care (PCY max)	\$2,500 CYD + 10% Coinsurance	\$2,500 CYD + 40% Coinsurance
Skilled Nursing Facility (PCY)	60 days CYD + 10% Coinsurance	60 days CYD + 40% Coinsurance
Hospice (Lifetime max)	\$7,500 CYD + 10% Coinsurance	\$7,500 CYD + 40% Coinsurance

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Benefits for Covered Services

Hospital/Surgical	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (ASC)	\$75 Copayment	CYD + 40% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (Option 1 / Option 2)	Rehabilitation Services limit - 21 days PCY \$400 Copayment / \$800 Copayment	Rehabilitation Services limit - 21 days PCY \$1,200 Copayment

Hospital/Surgical (Continued)		
Outpatient Hospital Facility Services (per visit) (Option 1 / Option 2)	\$100 Copayment / \$200 Copayment	\$300 Copayment
Emergency Room Facility Services (per visit) (copayment waived if admitted)	\$100 Copayment + 10% Coinsurance	\$100 Copayment + 40% Coinsurance

Financial Features		
Calendar Year Deductible (CYD) (per person / family aggregate) (CYD is the amount the member is responsible for before BCBSF pays)	\$500 / \$1,500	Combined w/ In-Network
Coinsurance (Coinsurance is the percentage the member pays for services)	10%	40%
Out-of-Pocket Maximum (per person / family aggregate) (Out-of-Pocket Maximum includes CYD, Coinsurance and Copayments; Excludes Prescription Drugs)	\$2,500 / \$7,500	Combined w/ In-Network
Total Lifetime Maximum Benefit	\$5,000,000	

Additional Benefits and Features

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Blue Cross and Blue Shield of Florida, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

1 CYD = Calendar Year Deductible
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Benefits for Covered Services

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at www.bcbsfl.com and other interactive web-based support tools
- **MyBlueService**, our 24/7 online member self-service, where you can request extra ID cards, review benefits, check claims status, print forms and more
- **Discounts** on vision care, hearing care, alternative care, fitness clubs, bicycle helmets and more through our BlueComplements program
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more**
- A quarterly **Personal Health Report**, and programs to reward you for staying healthy and participating in sports

Access to Our Strong Networks

NetworkBlueSM is the Preferred Provider Network designated as "In-Network" for BlueOptions. However, you will have **protection from balance billing** when you receive covered services from a provider in our Traditional Program Network. You may also receive **out-of-state coverage through the BlueCard[®]** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at www.bcbsfl.com.

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.

** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

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BlueScript Pharmacy Benefits

Your Prescription Drug Benefit Plan - 15/30/50 (Mail Order Available)

The BlueOptions health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain Prescription Drugs at a location convenient to you.

You may also be able to receive more savings on Prescription Drugs by purchasing your Drugs through the mail order program.

See below for your specific plan details.

Benefit Details (amount you pay):	
Deductible	\$0
Preferred Generic Prescription Drugs	\$15 Copayment (\$30 Mail Order Copayment)
Preferred Brand Name Prescription Drugs	\$30 Copayment (\$60 Mail Order Copayment)
Non-Preferred Prescription Drugs	\$50 Copayment (\$100 Mail Order Copayment)

Advantages of our Pharmacy Program:

With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs and Non-Preferred Prescription Drugs, easy access to Participating Pharmacies throughout Florida and access to National Network Pharmacies which have over 50,000 Participating Pharmacy locations.

Save when purchasing your Prescription Drugs:

You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These Prescription Drugs should cost you less than Prescription Drugs that are not on the list. For even greater savings, you will pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. The Preferred Medication List, which is part of the Medication Guide, will be delivered in your member package after you enroll. When reviewing the Preferred Medication List with your doctor, ask your provider to consider a Prescription Drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

The National Pharmacy Network:

The National Pharmacy Network includes more than 50,000 chain and independent Pharmacies across the United States. These National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Save through the convenient mail order program:

If you are taking, or plan on taking, Prescription Drugs for more than a three-month period, the mail order program offers you a convenient and cost-effective way to fill these Prescriptions. This program allows covered members taking Prescription Drugs to receive up to a full 90-day supply for one Mail Order Copayment. Prescription Drugs ordered through this program are provided by Prime Therapeutics'® mail order facility, PrimeMail®.

PPO Terms

Allowed Amount – The maximum amount an in-network provider is allowed to charge for a covered service

Balance Billing – The additional amount you may be billed if you seek care from an out-of-network provider

Co-Payment (copay) – The set amount you owe, if any, at the time of service

Co-Insurance (co-ins) – The percentage of the total charges you pay, if any, at the time of service

Covered Services – Medical services that are eligible for payment under your health plan

Deductible – The amount, if any, per calendar year, you owe before we begin to pay for covered services

In-Network – Refers to a provider who is a participant of NetworkBlue; you should pay less if you receive covered services from NetworkBlue providers.

NetworkBlue – The Preferred Provider Network made up of independent hospitals, physician and ancillary providers (i.e.; Family Physicians, Urgent Care Centers, Hospitals, etc...) who are considered participating for BlueOptions

Out-of-Pocket – What you pay for medical expenses. (i.e.; copays, coinsurance, deductible, etc...)

Out-of-Network – Refers to a provider not in NetworkBlue; in this case, your out-of-pocket costs will generally be higher

Out-of-pocket Maximum – The most you'll pay out of your wallet in a calendar year for health care expenses for any covered services you receive while in network

Provider – Any person or institution offering health care services, such as doctors, specialists, hospitals, labs, etc...