# Miami-Dade Blue

## For Individuals Under 65
## Benefit Summary Plan 1

### Benefits for Covered Services

*Amount Member Pays*

| 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. | **Plan 1** |
|---|---|
| **Office Services** | |
| **Physician Office Services**<br>(Includes routine check-ups, allergy injections in-office surgery, and e-office visits) | **In-Network:**<br>We pay $50 or the Allowed Amount[1] (whichever is lower) and the member pays the balance[2] up to Allowed Amount<br><br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |
| **Preventive Care** | |
| **Adult Wellness Benefit Maximum** | None |
| **Routine Adult Physical Exam and Immunizations** | **In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |
| **Well Woman Exam** (e.g. Annual GYN) | **In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |
| **Mammograms**<br>In-Network<br>Out-of-Network | <br>$0<br>DED[4] + 40% of Allowed Amount + the balance of provider's charges |
| **Well Child** (No PBP[3] max) | **In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |

[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

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

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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 |
| BlueScript Pharmacy benefit also provides coverage for prescription oral contraceptives, prescription diaphragms and diabetic equipment and supplies.<br>*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.<br>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. | |
| **Emergency Medical Care** | |
| **Urgent Care Centers** | **In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |
| **Emergency Room Facility Services (ER)** (per visit)<br>If Admitted or if a surgical service is performed<br>In-Network<br>Out-of-Network<br><br>Non-Surgical Services<br>Per Visit Deductible (PVD)<br>In-Network<br>Out-of-Network | <br><br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges<br><br>$500<br>PVD + DED + 10% of Allowed Amount<br>PVD + DED + 40% of Allowed Amount + balance of provider's charges |
| **Ambulance Services** (Ground travel / Air and water travel, per day maximum)<br>In-Network<br>Out-of-Network | $5,000<br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Outpatient Diagnostic Services** | |
| **Independent Diagnostic Testing Facility Services** (per visit)<br>(e.g. X-rays) (Includes Provider Services)<br>In-Network<br>Out-of-Network | <br><br>$75 Copayment<br>DED + 40% of Allowed Amount + the balance of provider's charges |
| **Independent Clinical Lab**<br>(e.g. Blood Work)<br>In-Network<br>Out-of-Network | <br><br>$0<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Outpatient Hospital Facility Services** (per visit) (Surgical Services Only)<br>(e.g. Surgeries, proximately related Blood Work and X-rays)<br>In-Network<br>Out-of-Network | <br><br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |

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| **Mental Health/Substance Dependency** | |
| **Mental Health** (Inpatient PBP / Outpatient PBP / Lifetime Maximum)<br>Inpatient Hospital Facility Services (per admit)<br>In-Network<br>Out-of-Network Per Admission Deductible (PAD)<br>Out-of-Network<br><br>Outpatient Office Visit | $2,000 / $600 / $10,000<br><br>DED + 10% of Allowed Amount<br>$500<br>PAD + DED + 40% of Allowed Amount + balance of provider's charges<br><br>**In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance of the provider's charge |
| **Substance Dependency** (Lifetime max)<br>Inpatient Hospital Facility Services (per admit)<br>In-Network<br>Out-of-Network Per Admission Deductible (PAD)<br>Out-of-Network<br><br>Outpatient Office Visit | $2,000<br><br>DED + 10% of Allowed Amount<br>$500<br>PAD + DED + 40% of Allowed Amount + balance of provider's charges<br><br>**In-Network:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>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**<br>If Admitted or if a surgical service is performed<br>In-Network<br>Out-of-Network<br><br>Non-Surgical Services at ER<br>Per Visit Deductible (PVD)<br>In-Network<br>Out-of-Network | <br><br>DED + 10% of Allowed Amount<br>DED + 10% of Allowed Amount + balance of provider's charges<br><br>$500<br>PVD + DED + 10% of Allowed Amount<br>PVD + DED + 10% of Allowed Amount + balance of provider's charges |
| **Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)**<br>In-Network<br>Out-of-Network | <br>DED + 10% of Allowed Amount<br>DED + 10% of Allowed Amount + balance of provider's charges |
| **Provider Services at Locations other than Office, Hospital and ER**<br>In-Network Family Physician / In-Network Specialist<br>Out-of-Network | <br>DED + 10% of Allowed Amount<br>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)<br>In-Network locations other than Hospital and Physician Office (e.g., PT Clinic)<br>Out-of-Network locations other than Hospital and Physician Office<br><br>Outpatient Hospital Facility | $1,500<br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges<br>Not Covered |
| **Durable Medical Equipment**<br>(If proximately related to surgery, Inpatient Admissions or ER services only)<br>In-Network<br>Out-of-Network | <br><br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Home Health Care** (PBP max)<br>In-Network<br>Out-of-Network | 45 Visits<br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Skilled Nursing Facility** (PBP max)<br>In-Network<br>Out-of-Network | 45 Days<br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Hospice** (Lifetime max)<br>In-Network<br>Out-of-Network | $5,200<br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Hospital/Surgical** | |
| **Ambulatory Surgical Center Facility (ASC)** (Surgical Services Only)<br>In-Network<br>Out-of-Network | <br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Inpatient Hospital Facility and Rehabilitation Services** (per admit)<br>In-Network<br>Out-of-Network Per Admission Deductible (PAD)<br>Out-of-Network | Rehabilitation Services limit - 21 days PBP<br>DED + 10% of Allowed Amount<br>$500<br>PAD + DED + 40% of Allowed Amount + balance of provider's charges |
| **Outpatient Hospital Facility Services** (per visit) (Surgical Services Only)<br>In-Network<br>Out-of-Network | <br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges |
| **Emergency Room Facility Services** (per visit)<br>If Admitted or if a surgical service is performed<br>In-Network<br>Out-of-Network<br><br>Non-Surgical Services<br>Per Visit Deductible (PVD)<br>In-Network<br>Out-of-Network | <br><br>DED + 10% of Allowed Amount<br>DED + 40% of Allowed Amount + balance of provider's charges<br><br>$500<br>PVD + DED + 10% of Allowed Amount<br>PVD + DED + 40% of Allowed Amount + balance of provider's charges |
| **Dental Coverage** | |
| **Preventive and Routine Dental Services**<br>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:**<br>We pay $50 or the Allowed Amount (whichever is lower) and the member pays the balance up to Allowed Amount<br><br>**Out-of-Network:**<br>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)<br>In-Network<br>Out-of-Network<br>Deductible (DED) is the amount the member is responsible for before BCBSF pays | $250 / N/A<br>$750 / N/A |
| **Per Admission Deductible (PAD)**<br>(Out-of-Network Inpatient Hospital Facility Services) | $500 |
| **Emergency Room Non-Surgical Per Visit Deductible (PVD)**<br>(Facility and Physician Services) | $500 |
| **Coinsurance** (Member pays)<br>In-Network<br>Out-of-Network<br>(Coinsurance is the percentage the member pays for services) | You pay 10% of the Allowed Amount<br>You pay 40% of the Allowed Amount + the balance of provider's charge |
| **Out-of-Pocket Maximum** (per person / family aggregate)<br>In-Network<br>Out-of-Network<br>(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 / N/A<br>$5,000 / N/A |
| **Total Lifetime Maximum Benefit** | $5,000,000 |

### 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.