



**BlueCross BlueShield
of Florida
Health Options®**

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

SCHOOL DISTRICT OF DESOTO COUNTY

BlueCare

For Large Groups
Benefit Summary Plan 16

Care must be received from or arranged by your Health Options contracting Primary Care Physician.

Benefits

Cost to You

Physician Office Services

Primary Care Physician office services	\$15 copay per visit
Contracting Specialist office services	\$45 copay per visit
One annual self-referral to contracting GYN for well-woman exam	\$45 copay per visit

These office services may include:

- Pediatric and well-baby care
- Periodic health evaluation and immunizations
- Other diagnostic services
- Health education
- Professional counseling
(family planning, nutritional, and medical social services)
- Vision and hearing screening
- Family planning services
- In-office surgery

Additional Services (Office or Outpatient Facility)

Allergy testing	No copay
Allergy injection, including serum	\$5 copay per visit
Outpatient physical, speech, cardiac and occupational therapies	\$5 copay per visit
Diagnostic lab and X-ray	No copay

Hospital Services (Inpatient Facility)

Room and board	\$300/day for days 1 – 5; maximum \$1,500/adm.
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These inpatient hospital services may include:

- Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications
- Intensive Care Unit and other special units
- Laboratory and X-ray services
- Inpatient physical, speech, cardiac and occupational therapies

Hospital or Ambulatory Surgical Center (Outpatient Facility)

Outpatient and outpatient surgical services may include:	\$300 copay
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications, including:	
• Hospital or surgical center	
• Surgeon's fees	



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- Outpatient laboratory, X-ray, and other tests

Benefits

Cost to You

Emergency Services (Hospital)

Use of emergency rooms and emergency services at contracting hospitals
Use of emergency rooms and emergency services outside of service area or at non-contracting hospitals

\$100 copay per visit
\$100 copay per visit

Maternity Services

Primary Care Physician office services
Contracting Specialist office services – initial OB visit only
Certified Nurse Midwife or Midwife
Inpatient hospital services

Birthing center services

\$15 copay
\$45 copay
No copay
\$300/day for days 1 – 5;
maximum \$1,500/adm.
No copay

Behavioral Health Services

Mental Health Care

- Outpatient visits – 20 per calendar year
- Inpatient facility – 30 days per calendar year
- Partial hospitalization (2 partial days for 1 inpatient day)

\$50 copay per visit
\$300/day for 1-5;
Maximum \$1,500/adm.
No copay

Substance dependency

- Outpatient visits – 20 per calendar year
- Inpatient hospitalization (detoxification only)

\$35 copay per visit
\$300/day for 1-5;
Maximum \$1,500/adm.

Infertility Services

Primary Care Physician
Contracting Specialist

\$15 copay per visit
\$45 copay per visit

Special Services

Hospice care
Skilled nursing facility – 90 days per calendar year
Home health care
Ambulance (medically necessary)
Durable medical equipment

No copay
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Prosthetics and orthotics

No copay



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Maximum Out-of-Pocket	\$1,500 per Member \$3,000 per family
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Additional information related to access to providers can be found in the Provider Directory.

Pre-existing Conditions Limitations

A pre-existing conditions limitation may apply for those who do not have a previous creditable coverage at enrollment. Please refer to the Master Policy for details.

Select Exclusions and Limitations

The following is a partial listing of services that are excluded from coverage under this agreement, but only if, and to the extent that, such exclusion is permitted under law. For a complete listing please refer to the Master Policy.

- All services not specifically listed in the Covered Services section of your Member Handbook or in any rider or endorsement, unless such services are specifically required by state or federal law
- Elective cosmetic surgery
- Hearing aids or eyeglasses, dental care, or oral appliances
- Physical for insurance, licensing, school or recreational purposes
- Elective abortions
- Workers' compensation
- Complementary and Alternative Healing Methods (CAM)
- **Prescription drugs** (unless include through BlueCare Rx)

Generic	\$10.00
Brand	\$30.00
Non-Preferred	\$45.00

Mail Order

Generic	\$20.00
Brand	\$60.00
Non-Preferred	\$90.00

The copayments are the responsibility of the Member and must be paid to the provider at the time service is rendered.

Should it become necessary, a grievance procedure is available to all Members, as detailed in the Master Policy.



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All health care services must be provided or authorized by your Primary Care Physician. This summary is only a partial description of the many benefits and services covered by Health Options, the HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. These benefits apply only to groups of 51 or more employees. Health Options, Inc. and Blue Cross and Blue Shield of Florida, Inc. are independent licensees of the Blue Cross and Blue Shield Association. This does not constitute a contract. For a complete description of benefits and exclusions, please see Master Policy 86002; its terms prevail.