



This welcome letter is only temporary. It will be replaced by a full color, tri-fold brochure in October that will give members great info on how to get started with their plan and tell them where to find their benefit info online.

Dear Valued Member,

Thank you for being a part of the Blue Cross and Blue Shield of Florida family. Inside you'll find **important health plan information** that opens the door to so much more!

When you have health care decisions to make, no one knows more about your health than you. We're here to help you *choose well, spend well and be well*. As a member, it helps to become familiar with all that Blue has to offer you.

### Getting Started ...

Here's what you can do to learn more about your plan, help save money and get answers to your health questions quickly:

**1. Create your online account, if you haven't already!**

Go to [www.bcbsfl.com](http://www.bcbsfl.com) to create your MyBlueService account — your place for personalized benefits and health information. Look for **New Member?** and click on **Register now to create a User ID and PIN**. All you need is an email address, your social security number and the member number on your ID card.

**2. See what's in MyBlueService.**

With MyBlueService, the health information you need is always at your fingertips — from what your plan benefits pay to details of what's been paid. From the task bar you can quickly find items, such as your Benefit Booklet. Plus you can look up health conditions, get estimates for treatment costs, compare prices, use interactive programs to help manage your health and more!

**3. Find doctors, hospitals and other providers.**

We make it easy to find providers that participate in your health plan — so you get the care you need and save the most you can on your out-of-pocket costs. On MyBlueService, simply click on **Find a Doctor & More**.

### You can count on us ...

We're here to answer your questions and help you feel more confident about your health care decisions. Your benefit booklet is available online but we will also mail a copy upon request. You can reach us at **1-800-FLA-BLUE** (352-2583) or meet with us in person at a Florida Blue Center near you. Go to [www.FloridaBlue.com](http://www.FloridaBlue.com) for locations and hours.

Thank you for choosing Blue!

Sincerely,

A handwritten signature in black ink that reads "Darnell Smith".

Darnell Smith  
Group Vice President  
Service Organization

Si desea hablar sobre esta carta en español con uno de nuestros representantes, por favor llame al número de atención al cliente indicado en su tarjeta de asegurado y pida ser transferido a un representante bilingüe.

# BlueOptions

## Schedule of Benefits – Plan 03769

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at [www.bcbsfl.com](http://www.bcbsfl.com). If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

**Your Benefit Period**..... 1/1/11 – 12/31/11

### Deductible, Coinsurance and Out-of-Pocket Maximums

| Benefit Description  | In-Network     | Out-of-Network |
|--|----------------|----------------|
| <b>Deductible (DED)</b>  |                |                |
| Per Person per Benefit Period  | \$500          | \$1,000        |
| Per Family per Benefit Period  | \$1,000        | \$2,000        |
| <b>Per Admission Deductible (PAD)</b>  | Not Applicable | Not Applicable |
| <b>Coinsurance</b><br>(The percentage of the Allowed Amount <b>you pay</b> for Covered Services) | 20%            | 50%            |
| <b>Out-of-Pocket Maximums</b>  |                |                |
| Per Person per Benefit Period  | \$4,000        | \$6,000        |
| Per Family per Benefit Period  | \$8,000        | \$12,000       |

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?

- DED
- PAD, when applicable
- Coinsurance
- Copayments

What **does not apply** to out-of-pocket maximums?

- Non-covered charges
- Any benefit penalty reductions
- Charges in excess of the Allowed Amount
- Any Prescription Drug Cost Share amounts (except for Medical Pharmacy Services)

### **Important information affecting the amount you will pay:**

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

## Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

| Benefit Description   | In-Network | Out-of-Network |
|---|------------|----------------|
| <b>Office visits</b> and Services not otherwise outlined in this table rendered by<br>Family Physicians                           | \$25       | DED + 50%      |
| Other health care professionals licensed to perform such Services   | \$45       | DED + 50%      |
| <b>Advanced Imaging Services</b><br>(CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by<br>Family Physicians | \$25       | DED + 50%      |
| Other health care professionals licensed to perform such Services   | \$45       | DED + 50%      |
| <b>Allergy Injections</b> rendered by<br>Family Physicians  | \$10       | DED + 50%      |
| Other health care professionals licensed to perform such Services   | \$10       | DED + 50%      |
| <b>E-Visits</b> rendered by<br>Family Physicians  | \$10       | DED + 50%      |
| Other health care professionals licensed to perform such Services   | \$10       | DED + 50%      |
| <b>Durable Medical Equipment, Prosthetics, and Orthotics</b><br><b>Note:</b> Includes Compression Hose/Stockings                  | \$0        | DED + 50%      |
| <b>Convenient Care Centers</b>  | \$60       | \$60           |
| <b>Hearing Exams</b>  | \$45       | DED + 50%      |

## Preventive Health Services

| Benefit Description   | In-Network | Out-of-Network |
|---|------------|----------------|
| <b>Adult Wellness Services</b><br>Rendered by<br>Family Physicians        | \$0        | 50%            |
| Other health care professionals licensed to perform such Services         | \$0        | 50%            |
| All other locations   | \$0        | 50%            |
| <b>Adult Well Woman Services</b><br>Rendered by<br>Family Physicians      | \$0        | 50%            |
| Other health care professionals licensed to perform such Services         | \$0        | 50%            |
| All other locations   | \$0        | 50%            |
| <b>Child Health Supervision Services</b> rendered by<br>Family Physicians | \$0        | 50%            |
| Other health care professionals licensed to perform such Services         | \$0        | 50%            |
| All other locations   | \$0        | 50%            |
| <b>Mammograms</b>   | \$0        | \$0            |
| <b>Routine Colonoscopy</b>  | \$0        | \$0            |

## Outpatient Diagnostic Services

| Benefit Description  | In-Network                              | Out-of-Network |
|--|---|----------------|
| <b>Independent Clinical Lab</b>  | \$0                                     | DED + 50%      |
| <b>Independent Diagnostic Testing Facility</b><br>Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) | \$80                                    | DED + 50%      |
| All other diagnostic Services (e.g., X-rays)   | \$80                                    | DED + 50%      |
| <b>Outpatient Hospital Facility</b>  | See <b>Hospital Services Outpatient</b> |                |

## Emergency and Urgent Care Services

| Benefit Description          | In-Network   | Out-of-Network |
|------------------------------|--|----------------|
| <b>Ambulance Services</b>    | \$0  |                |
| <b>Emergency Room Visits</b> | See <b>Hospital Services Emergency Room Visits</b> |                |
| <b>Urgent Care Center</b>    | \$60   | \$60           |

## Outpatient Surgical Services

| Benefit Description                               | In-Network | Out-of-Network       |
|---|------------|----------------------|
| <b>Ambulatory Surgical Center</b>                 |            |                      |
| Facility (per visit)                              | \$150      | DED + 50%            |
| Radiologists, Anesthesiologists, and Pathologists | DED + 20%  | In-Network DED + 20% |
| Colonoscopy                                       | \$45       | DED + 50%            |
| Colonoscopy Pathology Services                    | \$0        | DED + 50%            |

| <b>Benefit Description</b>  | <b>In-Network</b>                       | <b>Out-of-Network</b> |
|---|---|-----------------------|
| Other health care professional Services rendered by all other Providers |   |                       |
| a. Family Physicians  | \$25                                    | DED + 50%             |
| b. Other health care professionals licensed to perform such Services    | \$45                                    | DED + 50%             |
| <b>Outpatient Hospital Facility</b>                                     | <b>See Hospital Services Outpatient</b> |                       |

### Hospital Services

| <b>Benefit Description</b>                            | <b>In-Network</b> |   | <b>Out-of-Network</b> |
|---|-------------------|---|-----------------------|
|   | <b>Option 1*</b>  | <b>Option 2* and Out-of-State BlueCard® Participating</b> |                       |
| <b>Inpatient</b>                                      |                   |   |                       |
| Facility Services ( per admission)                    | DED + 25%         | DED + 25%   | DED + 50%             |
| Physician and other health care professional Services | DED + 20%         |   | DED + 50%             |

| Benefit Description                                   | In-Network                 |  | Out-of-Network |
|---|----------------------------|--|----------------|
|   | Option 1*<br>and Option 2* | Out-of-State<br>BlueCard®<br>Participating |                |
| <b>Outpatient</b>                                     |                            |  |                |
| Facility (per visit)                                  | \$250                      | DED + 20%                                  | DED + 50%      |
| Physician and other health care professional Services | DED + 20%                  |  | DED + 50%      |
| Therapy Services                                      | \$250                      | \$250                                      | DED + 50%      |
| <b>Emergency Room Visits</b>                          |                            |  |                |
| Facility (Copayment waived if admitted)               | \$300                      |  | \$300          |
| Physician and other health care professional Services | \$0                        |  | \$0            |

**Important:**

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. We will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not participating in our Traditional Program, you will be responsible for the difference between what we pay and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

\*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

## Behavioral Health Services

| Benefit Description   | In-Network | Out-of-Network |
|---|------------|----------------|
| <b>Mental Health Services</b>   |            |                |
| Outpatient  |            |                |
| Facility Services rendered at:  |            |                |
| Emergency Room  | \$300      | \$300          |
| Hospital  | \$250      | DED + 50%      |
| Physician Services at Hospital  | DED + 20%  | DED + 50%      |
| Physician Services at ER  | \$0        | \$0            |
| Physician and other health care professionals licensed to perform such Services |            |                |
| Family Physician office   | \$25       | DED + 50%      |
| Specialist office   | \$45       | DED + 50%      |
| All other locations   |            |                |
| a. Family Physician   | \$25       | DED + 50%      |
| b. Other health care professionals licensed to perform such Services            | \$45       | DED + 50%      |
| Inpatient   |            |                |
| Facility Services   | DED + 25%  | DED + 50%      |
| Physician and other health care professionals licensed to perform such Services | DED + 20%  | DED + 50%      |

| Benefit Description  | In-Network  | Out-of-Network  |
|--|---|---|
| <p><b>Substance Dependency Care and Treatment Services</b></p> <p>Outpatient</p> <p>Facility Services rendered at:</p> <p>Emergency Room</p> <hr/> <p>Hospital</p> <hr/> <p>Physician Services at Hospital</p> <hr/> <p>Physician Services at ER</p> | <p>\$300</p> <hr/> <p>\$250</p> <hr/> <p>DED + 20%</p> <hr/> <p>\$0</p> | <p>\$300</p> <hr/> <p>DED + 50%</p> <hr/> <p>DED + 50%</p> <hr/> <p>\$0</p> |
| <p>Physician and other health care professionals licensed to perform such Services</p> <p>Family Physician office</p> <hr/> <p>Specialist office</p>   | <p>\$25</p> <hr/> <p>\$45</p>   | <p>DED + 50%</p> <hr/> <p>DED + 50%</p>                                     |
| <p>All other locations</p> <p>a. Family Physician</p> <hr/> <p>b. Other health care professionals licensed to perform such Services</p>  | <p>\$25</p> <hr/> <p>\$45</p>   | <p>DED + 50%</p> <hr/> <p>DED + 50%</p>                                     |
| <p>Inpatient</p> <p>Facility Services</p> <hr/> <p>Physician and other health care professionals licensed to perform such Services</p>   | <p>DED + 25%</p> <hr/> <p>DED + 20%</p>                                 | <p>DED + 50%</p> <hr/> <p>DED + 50%</p>                                     |

## All Other Services

| Benefit Description | In-Network | Out-of-Network |
|---------------------|------------|----------------|
| Hospice Benefits    | \$0        | DED + 50%      |

## Benefit Maximums

**Ambulance Services** Per day for ground, air and water travel ..... \$5,000

**Exception to per day Maximum:** Covered expenses for Ambulance Services for a newborn child, as described in the Newborn Assessment provision of the “What Is Covered?” section of the Booklet, are limited to a maximum of \$1,000 per day.

**Note:** In addition to the Cost Share listed in this Schedule of Benefits you are responsible for any additional amounts that exceed the per day maximum.

### Autism Spectrum Disorder Services

Per Benefit Period..... Unlimited  
Per Lifetime..... Unlimited

**Enteral Formula** per Benefit Period..... \$5,000

**Eye Glasses Following Cataract Surgery** paid at 100%, DED waived  
up to Per Person Maximum of ..... \$150

**Home Health Care** Visits per Benefit Period..... 80

**Note:** Home Health Care benefits are covered at 100%, DED waived.

**Inpatient Rehabilitation** days per Benefit Period..... 21

**Outpatient Therapies and Spinal Manipulations** Visits per Benefit Period..... 80

**Note:** Refer to the Benefit Booklet for reimbursement guidelines.

**Preventive Adult Wellness** per Benefit Period ..... Unlimited

### Preventive Adult Wellness Services include:

1. annual physical or gynecological exam, including family planning/contraceptive Services; and
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory Services, and immunizations.

**Note:** The wellness Services above are not subject to the DED when rendered by an In-Network Provider. Your share of the expenses may vary based on the location of service and whether the Provider is In-Network or Out-of-Network. Routine hearing examinations and screenings and flu shots are not subject to the Preventive Adult Wellness maximum. Additionally, flu shots will be covered at 100% when rendered during on-site school injections, otherwise the office Copayment will apply.

**Skilled Nursing Facility** days per Benefit Period ..... 120

**Total Lifetime Maximum Benefit** ..... Unlimited

**Wigs** (Incident to treatment for cancer) Paid at 100%, DED waived,  
up to the Per Person Per Benefit Period maximum of ..... \$500

## **Additional Benefits/Features**

### **Benefit Maximum Carryover**

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums and Lifetime maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums and Lifetime maximums under this plan.

### **Prescription Drug Program**

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

The next three pages are the HIPAA Privacy Notice and the WHCRA Notice. We are required to provide these in writing to all members upon enrollment. They will be stapled to the Schedule of Benefits.

**Please review carefully. This notice describes how health information about you may be used and disclosed and how you can get access to this information.**

## **Health Insurance Portability And Accountability Act Administrative Simplification (HIPAA-AS) Notice of Privacy Practices**

### **Our Legal Duty**

As your health plan, we are required by applicable federal and state laws to maintain the privacy of your protected health information (PHI). This notice describes our privacy practices, our legal duties, and your rights concerning your PHI. We will follow the privacy practices that are described in this notice while it is in effect. This notice took effect **April 14, 2003**, and will remain in effect until a revised notice is issued.

We reserve the right to change our privacy practices and the terms of this notice at any time and to make the terms of our notice effective for all PHI that we maintain.

Before we make a significant change in our privacy practices, we will change this notice and send the new notice to you.

### **How we can use or disclose PHI without a specific authorization**

**To You:** We must disclose your PHI to you, as described in the Individual Rights section of this notice.

**For Treatment:** For example, we may disclose PHI in an electronic health record we create from claims information, to a doctor or hospital at their request, in order for them to provide treatment to you. Additionally we may disclose

PHI to a doctor, dentist or a hospital at their request for their treatment purposes.

**For Payment:** For example, we may use and disclose PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may also disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.

**For Health Care Operations:** For example, we may use or disclose PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health related benefits and services or treatment alternatives that may be of interest to you. We may also disclose PHI to a health care provider or another health plan subject to federal privacy laws, as long as the provider or plan has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider or plan. We may also disclose PHI to other entities with which we have contracted to perform or provide certain services on our behalf (i.e. business associates).

**For Public Health and Safety:** We may use or disclose PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.

**As Required by Law:** We may use or disclose PHI when we are required to do so by law.

**For Process and Proceedings:** We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

**For Law Enforcement:** We may disclose PHI to a law enforcement official with regard to crime victims and criminal activities.

**Special Government Functions:** We may disclose the PHI of military personnel or inmates or other persons in lawful custody under certain circumstances. We may disclose PHI to authorized federal officials for lawful national security activities.

**To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose

summary health information to the plan sponsor so that the plan sponsor may either: obtain premium bids or decide whether to amend, modify or terminate your group health plan.

**For Research, Death, and Organ Donation:** We may use or disclose PHI in certain circumstances related to research, death or organ donation.

**For Workers' Compensation:** We may disclose PHI as permitted by workers' compensation and similar laws.

**Uses and disclosures of PHI permitted only after authorization is received**

**Authorization:** You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

**To Family and Friends:** While the law permits us in certain circumstances to disclose your PHI to family, friends and others, we will do so only with your authorization. In the event you are unable to authorize such disclosure, but emergency or similar circumstances indicate that disclosure would be in your best interest, we may disclose your PHI to family, friends or others to the extent necessary to help with your health care coverage arrangements.

**Individual Rights**

*To exercise any of these rights, please call the customer service number on your ID card.*

**Access:** With limited exceptions, you have the right to review in person, or obtain copies of, your PHI. We may charge you a reasonable fee as allowed by law.

**Amendment:** With limited exceptions, you have the right to request that we amend your PHI.

**Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as allowed by law to respond to any additional request.

**Use/Disclosure Restriction:** You have the right to request that we restrict our use or disclosure of your PHI for certain purposes. We are not required to agree to a requested restriction. We will agree to restrict use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to a restriction request, we may still disclose your PHI in a medical emergency, and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

**Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a PHI address.

Note: If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.

**Privacy Notice:** You have the right to request and receive a copy of this notice at any time. For more information or if you have questions about this notice, please contact us using the information listed at the end of this notice.

**Complaints**

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact:** Corporate Compliance Office  
Blue Cross and Blue Shield of Florida  
PO Box 44283  
Jacksonville, FL 32203-4283  
1-888-574-2583

**NOTICE  
REGARDING COVERAGE FOR  
BREAST RECONSTRUCTION SURGERY**

The law<sup>1</sup>, referred to as “The Women’s Health And Cancer Rights Act of 1998”, regarding breast cancer and reconstructive surgery, requires insurers offering group health insurance coverage, as well as all group health plans (employers), which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

An insurer offering group health insurance coverage or group health plans (employers) may not:

- deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the individual health insurance coverage or group health plan, solely for the purpose of avoiding the requirements of the Women’s Health And Cancer Rights Act of 1998; and
- penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such a provider to provide care to an individual participant or beneficiary in a manner inconsistent with the Women’s Health And Cancer Rights Act of 1998.

Nothing in this law shall be construed to prevent an insurer offering group health coverage or a group health plan (employer) from negotiating the level and type of reimbursement with a provider for care provided in accordance with this act.

“The Women’s Health And Cancer Rights Act of 1998” shall apply to group health plans with respect to plan years beginning on or after October 21, 1998. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this act shall not be treated as a termination of such collective bargaining agreement.

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<sup>1</sup> 1999 Omnibus Consolidated and Emergency Supplemental Appropriations Act (HR 4328; P.L. 105-277). This law, Title IX - Women’s Health And Cancer Rights Act of 1998, amended the Employee Retirement Income Security Act of 1974 (ERISA; 29 U.S.C. 1185 et seq.) and subpart 3 of part B of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.).



XOPID02 10076 00001 2  
 07168001 01  
 JOHN A. SAMPLE  
 4800 DEERWOOD CAMPUS PKWY  
 JACKSONVILLE FL

# Thank you for choosing Blue Cross and Blue Shield of Florida.

Attached are your new ID cards.  
Please discard your old cards.

Visit **MyBlueService** at [www.bcbsfl.com](http://www.bcbsfl.com) to access your benefit information, research online health resources and order additional ID cards.



BlueCross BlueShield  
of Florida

BlueOptions

**JOHN A. SAMPLE**

Member Number

**XJBH999999999**

Physician Copay \$25

Specialist \$50

BC **090** BS **590**

Rx BIN **012833**

PCN **FLBC**

Group Number **07168**



BlueCross BlueShield  
of Florida

BlueOptions

**JOHN A. SAMPLE**

Member Number

**XJBH999999999**

Physician Copay \$25

Specialist \$50

BC **090** BS **590**

Rx BIN **012833**

PCN **FLBC**

Group Number **07168**





By accepting this card and any benefits to which this card entitles the holder, the holder acknowledges that the contract pursuant to which this card is issued constitutes an agreement solely between the contract holder and Blue Cross and Blue Shield of Florida, and that Blue Cross and Blue Shield of Florida is an independent corporation operating under a license from the Blue Cross and Blue Shield Association that permits Blue Cross and Blue Shield of Florida to use the Blue Cross and Blue Shield Names and Services Marks in the State of Florida.

MyBlueService at [www.bcbsfl.com](http://www.bcbsfl.com)  
24/7 Member Self-Service Center

[www.bcbsfl.com](http://www.bcbsfl.com)



**HOW CAN BLUE HELP YOU?**

**Notice to Participating Provider:** Collect for coinsurance, copay, deductible, and any non-covered services only. Patient is not responsible for the difference between your charge and our allowance.

When submitting claims and/or inquiries, always include the name and complete member number, including the alpha prefix, as shown on the front of the card.

**Pharmacies:** For claims submission and other helpful information, visit [www.bcbsfl.com](http://www.bcbsfl.com).

**Out-of-State Providers:** Submit all claims to the Blue Cross and Blue Shield Plan serving your area.

Customer Service: **1-800-352-2583**  
[www.bcbsfl.com/MyBlueService](http://www.bcbsfl.com/MyBlueService)  
Admission Notification: **1-800-955-5692**  
Outside of Florida: **1-800-810-2583**

**Florida Providers Send Claims to:**  
P.O. BOX 1798 JACKSONVILLE, FL 32231

Blue Cross and Blue Shield of Florida is an independent licensee of the Blue Cross and Blue Shield Association.

Possession of this card does not guarantee eligibility for benefits.

To locate a participating provider outside of Florida, call the number above or visit [www.bcbs.com](http://www.bcbs.com).

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[www.bcbsfl.com](http://www.bcbsfl.com)



**HOW CAN BLUE HELP YOU?**

**Notice to Participating Provider:** Collect for coinsurance, copay, deductible, and any non-covered services only. Patient is not responsible for the difference between your charge and our allowance.

When submitting claims and/or inquiries, always include the name and complete member number, including the alpha prefix, as shown on the front of the card.

**Pharmacies:** For claims submission and other helpful information, visit [www.bcbsfl.com](http://www.bcbsfl.com).

**Out-of-State Providers:** Submit all claims to the Blue Cross and Blue Shield Plan serving your area.

Customer Service: **1-800-352-2583**  
[www.bcbsfl.com/MyBlueService](http://www.bcbsfl.com/MyBlueService)  
Admission Notification: **1-800-955-5692**  
Outside of Florida: **1-800-810-2583**

**Florida Providers Send Claims to:**  
P.O. BOX 1798 JACKSONVILLE, FL 32231

Blue Cross and Blue Shield of Florida is an independent licensee of the Blue Cross and Blue Shield Association.

Possession of this card does not guarantee eligibility for benefits.

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