EE Family 05180 | 05181

2017-2018 PRM Benefits

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The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE). Benefits and rates reflected in the proposal are subject to change based on the outcomes of the test.

| COST SHARING | BlueOptions HSA-Compatible 05180 | BlueOptions |
|---|---|---|
| Maximums shown are Per Benefit Period (BPM) | (Single Coverage) | HSA-Compatible 05181 (Family Coverage) |
| unless noted | | (i anny covalage) |
| Deductible (DED) (Per Person/Family Agg) | | |
| In-Network | \$2,500 / Not Applicable | \$5 000 1 \$5 000 |
| Out-of-Network | \$5,000 / Not Applicable | \$5,000 / \$5,000 \$10,000 / \$10,000 |
| Coinsurance (Member Responsibility) | Philippine and the second | \$10,0007\$10,000 |
| In-Network | 0% | 0% |
| Out-of-Network | 20% | 20% |
| Out of Pocket Maximum (Per Person/Family Agg) | Includes DED, Coins, & | Includes DED, Coins, & |
| Im Made and | Copays | Copays |
| In-Network Out-of-Network | \$2,500 / Not Applicable | \$5,000 / \$5,000 |
| Lifetime Maximum | \$10,000 / Not Applicable | \$20,000 / \$20,000 |
| | No Maximum | No Maximum |
| PROFESSIONAL PROVIDER SERVICES | AND NOT THE REAL | THE PARTY OF LOTS |
| Allergy Injections | the second se | |
| In-Network Family Physician | DED | DED |
| In-Network Specialist | DED | DED |
| Out-of-Network | DED + 20% | DED + 20% |
| E-Office Visit Services | 1945 - Fi | |
| In-Network Family Physician | DED | DED |
| In-Network Specialist Out-of-Network | DED | DED |
| Office Services | DED + 20% | DED + 20% |
| In-Network Family Physician | | |
| In-Network Specialist | DED | DED |
| Out-of-Network | DED | DED |
| Provider Services at Hospital and ER | DED + 20% | DED + 20% |
| In-Network Family Physician | Dirp | |
| In-Network Specialist | DED DED | DED |
| Out-of-Network | In-Ntwk DED (No Coins) | DED |
| Provider Services at Other Locations | interview Dep (inio Collis) | In-Ntwk DED (No Coins) |
| In-Network Family Physician | DED | DED |
| In-Network Specialist | DED | DED |
| Out-of-Network | DED + 20% | DED + 20% |
| Radiology, Pathology and Anesthesiology | | DED + 20% |
| Provider Services at Hospital or Ambulatory | | |
| Surgical Center | | |
| In-Network Specialist Out-of-Network | DED | DED |
| | In-Ntwk DED (No Coins) | In-Ntwk DED (No Coins) |
| PREVENTIVE CARE | A AL ENGLY SAME T | And the second se |
| Adult Wellness Office Services | | THE PART OF THE PARTY OF |
| In-Network Family Physician | \$0 | \$0 |
| In-Network Specialist | \$0 | SO |
| Out-of-Network | 20% (No DED) | 20% (No DED) |
| Colonoscopies (Routine) | Age 50+ then Frequency | Age 50+ then Frequency |
| In-Network | Schedule Applies | Schedule Applies |
| Out-of-Network | \$0 | \$0 |
| Mammograms (Routine and Dx) | \$0 | \$0 |
| In-Network | | |
| Out-of-Network | \$0 | \$0 |
| Well Child Office Visits (No BPM) | \$0 | \$0 |
| In-Network Family Physician | 60 | |
| | \$0 | \$0 |

Blue Cross and Blue Shield

| COST SHARING Aaximums shown are Per Benefit Period (BPM) | BlueOptions HSA-Compatible 05180 (Single Coverage) | BlueOptions HSA-Compatible 05181 (Family Coverage) |
|--|--|--|
| Inless noted In-Network Specialist Out-of-Network | \$0 20% (No DED) | \$0 20% (No DED) |
| MERGENCY/URGENT/CONVENIENT CARE | | 20% (NO DED) |
| Ambulance Maximum (per Day) | \$5,500 | ¢5 500 |
| In-Network | DED | \$5,500 DED |
| Out-of-Network | In-Ntwk DED (No Coins) | In-Ntwk DED (No Coins) |
| Convenient Care Centers (CCC) | | |
| Out-of-Network | DED | DED |
| mergency Room Facility Services | DED + 20% | DED + 20% |
| also see Professional Provider Services) | | |
| In-Network | DED | DED |
| Out-of-Network Jrgent Care Centers (UCC) | OON DED (No Coins) | OON DED (No Coins) |
| In-Network | | |
| Out-of-Network | DED | , DED |
| ACILITY SERVICES - HOSP/SURG/ICL/IDTF Inless otherwise noted, physician services are in addition to facility services. See Professional Provider Services | | DED |
| Ambulatory Surgical Center In-Network | DED | DED |
| Out-of-Network ndependent Clinical Lab | DED + 20% | DED + 20% |
| in-Network | - | |
| Out-of-Network | DED DED + 20% | DED |
| ndependent Diagnostic Testing Facility - | DED T 20% | DED + 20% |
| (rays and AIS (Includes Physician Services) | | |
| In-Network - Advanced Imaging Services (AIS) | DED | DED |
| In-Network - Other Diagnostic Services Out-of-Network | DED | DED |
| npatient Hospital (per admit) | DED + 20% | DED + 20% |
| in-Network | Option 1 - DED | Option 1 - DED |
| and the second | Option 2 - DED | Option 2 - DED |
| Out-of-Network Out-of-Network (Emergency Admission) | DED + 20% | DED + 20% |
| npatient Rehab Maximum | DED | DED |
| Outpatient Hospital (per visit) | 30 Days | 30 Days |
| In-Network | Option 1 + DED | Option 1 - DED |
| Out-of-Network | Option 2 - DED | Option 2 - DED |
| Therapy at Outpatient Hospital | DED + 20% | DED + 20% |
| In-Network | Option 1 - DED | Online 4 DED |
| | Option 2 - DED | Option 1 - DED Option 2 - DED |
| Out-of-Network | DED + 20% | DED + 20% |
| MENTAL HEALTH AND SUBSTANCE ABUSE npatient Hospitalization (30 day max) | | RITTI |
| inpatient nospitalization (30 day max) | 0.0 | |
| In-Network | Option 1 - DED Option 2 - DED | Option 1 - DED |
| Out-of-Network | DED + 20% | Option 2 - DED DED + 20% |
| Out-of-Network (Emergency Admission) | DED | DED |
| Outpatient Hospitalization (per visit) | College 2 Date | |
| In-Network | Option 1 - DED Option 2 - DED | Option 1 - DED |
| Out-of-Network | DED + 20% | Option 2 - DED DED + 20% |
| Provider Services at Hospital and ER | | |
| In-Network Family Physician or Specialist Out-of-Network Provider | DED | DED |
| Physician Office Visit | In-Ntwk DED (No Coins) | In-Ntwk DED (No Coins |
| In-Network Family Physician or Specialist | DED | DED |
| Out-of-Network Provider | DED + 20% | DED DED + 20% |
| Emergency Room Facility Services (per visit) In-Network | | A CONTRACT OF STATES |
| Out-of-Network | DED OON DED (No Onion) | DED |
| Provider Services at Locations other than | OON DED (No Coins) | OON DED (No Coins) |
| Hospital and ER | | |
| In-Network Family Physician | DED | DED |
| In-Network Specialist Out-of-Network Provider | DED | DED |
| •THER SPECIAL SERVICES AND LOCATIONS | DED + 20% | DED + 20% |
| Advanced Imaging Services in Physician's Office | 10.40 (A) 18 18 1 | M. L. M. C. |
| In-Network Family Physician | DED | DED |

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Blue Cross and Blue Shield c of th

| ptions | BlueOption | BlueOptions HSA-Compatible 05180 | COST SHARING |
|---|---------------------------------------|---|---|
| atible 05181 Coverage) | HSA-Compatible ((Family Coverage) | (Single Coverage) | Maximums shown are Per Benefit Period (BPM) unless noted |
| | | | In-Network Specialist |
| ED | DED | DED | Out-of-Network |
| + 20% | DED + 20% | DED + 20% | Birthing Center |
| 開始が見た | | | In-Network |
| | DED | DED, | Out-of-Network |
| + 20% | DED + 20% | DED + 20% | Diabetic Equipment and Supplies* |
| **** 4 8. D | | | In-Network |
| ED | DED | DED | Out-of-Network |
| + 20% | DED + 20% | DED + 20% | |
| ximum | No Maximum | No Maximum | Durable Medical Equipment, Prosthetics, Orthotics BPM |
| 1 | and the second second | 3 A | In-Network |
| ED | DED | DED | Out-of-Network |
| + 20% | DED + 20% | DED + 20% | Home Health Care BPM |
| | 20 Visits | 20 Visits | |
| | DED | DED | In-Network |
| + 20% | DED + 20% | DED + 20% | Out-of-Network |
| | No Maximum | No Maximum | Hospice LTM |
| the second se | DED | DED | In-Network |
| the second s | DED + 20% | DED + 20% | Out-of-Network |
| | 35 Visits (Includes u | 35 Visits (Includes up to 26 | Outpatient Therapy and Spinal Manipulations |
| ninulations) | Spinal Manipulat | Spinal Manipulations) | BPM |
| | 60 Davs | 60 Days | Skilled Nursing Facility BPM |
| | DED | DED | In-Network |
| | DED + 20% | DED + 20% | Out-of-Network |
| 2078 | 010 20/6 | A CONTRACTOR OF THE OWNER | PRESCRIPTION DRUGS |
| - Brooking a Wilson | No. As And South St | | Deductible |
| outra de teux | Street street. | | In-Network |
| ar IN DED | 100% after IN D | 100% after IN DED | Retail (30 Days) |
| or the participation | TODYO CITCH ITS D | | Generic/Preferred Brand/Non-Preferred |
| or INLIDED | 100% after IN C | 100% after IN DED | Mail Order (90 Days) |
| | TWO IN CITCH IN C | | Generic/Preferred Brand/Non-Preferred |
| | and increasing the second | a second sponsor and the second se | Out-of-Network |
| | | | Retail (30 Days) |
| | 50% after IN D | 50% after IN DED | Generic/Preferred Brand/Non-Preferred |
| | | | Mail Order (90 Days) |
| | 50% after IN D | 50% after IN DED | Generic/Preferred Brand/Non-Preferred |
| | JU % alter IN D | | Medical Pharmacy (Provider-Administered Rx)** |
| he at Onistal | See Location of S | See Location of Service | In-Network |
| on of Sand | See Location of S | See Location of Service | Out-of-Network |
| on or service | See Location of S | | |
| | | | |
| | | | |
| | | | |

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations;

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 Benefit Booklet and Schedule of Benefits; their terms prevail.

Blue Options 05180/81 Premium as of: 10/1/17

Employee: 576.02 Add'l Sponse: 795.96 Add'l Children: 499.90 Family: 1,128.81

Hmo Plan EE : 728,17 Spouse: 990.64 Gaildrem: 622.31 Family: 1,405.12

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