

2017-2018 PRM Benefits

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 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)
Maximums shown are Per Benefit Period (BPM) unless noted		
Deductible (DED) (Per Person/Family Agg)		
In-Network	\$2,500 / Not Applicable	\$5,000 / \$5,000
Out-of-Network	\$5,000 / Not Applicable	\$10,000 / \$10,000
Coinsurance (Member Responsibility)		
In-Network	0%	0%
Out-of-Network	20%	20%
Out of Pocket Maximum (Per Person/Family Agg)		
In-Network	Includes DED, Coins, & Copays	Includes DED, Coins, & Copays
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	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network	DED + 20%	DED + 20%
E-Office Visit Services		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Office Services		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Provider Services at Hospital and ER		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network	In-Ntwk DED (No Coins)	In-Ntwk DED (No Coins)
Provider Services at Other Locations		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Radiology, Pathology and Anesthesiology		
Provider Services at Hospital or Ambulatory Surgical Center		
In-Network Specialist	DED	DED
Out-of-Network	In-Ntwk DED (No Coins)	In-Ntwk DED (No Coins)
PREVENTIVE CARE		
Adult Wellness Office Services		
In-Network Family Physician	\$0	\$0
In-Network Specialist	\$0	\$0
Out-of-Network	20% (No DED)	20% (No DED)
Colonoscopies (Routine)		
In-Network	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
Out-of-Network	\$0	\$0
Mammograms (Routine and Dx)		
In-Network	\$0	\$0
Out-of-Network	\$0	\$0
Well Child Office Visits (No BPM)		
In-Network Family Physician	\$0	\$0

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)
In-Network Specialist	\$0	\$0
Out-of-Network	20% (No DED)	20% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance Maximum (per Day)	\$5,500	\$5,500
In-Network	DED	DED
Out-of-Network	In-Ntwk DED (No Coins)	In-Ntwk DED (No Coins)
Convenient Care Centers (CCC)		
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	DED	DED
Out-of-Network	OON DED (No Coins)	OON DED (No Coins)
Urgent Care Centers (UCC)		
In-Network	DED	DED
Out-of-Network	DED	DED
FACILITY SERVICES - HOSP/SURG/CL/IDTF		
Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center		
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Independent Clinical Lab		
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS)	DED	DED
In-Network - Other Diagnostic Services	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Inpatient Hospital (per admit)		
In-Network	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED
Out-of-Network	DED + 20%	DED + 20%
Out-of-Network (Emergency Admission)	DED	DED
Inpatient Rehab Maximum	30 Days	30 Days
Outpatient Hospital (per visit)		
In-Network	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED
Out-of-Network	DED + 20%	DED + 20%
Therapy at Outpatient Hospital		
In-Network	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED
Out-of-Network	DED + 20%	DED + 20%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization (30 day max)		
In-Network	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED
Out-of-Network	DED + 20%	DED + 20%
Out-of-Network (Emergency Admission)	DED	DED
Outpatient Hospitalization (per visit)		
In-Network	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED
Out-of-Network	DED + 20%	DED + 20%
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	DED	DED
Out-of-Network Provider	In-Ntwk DED (No Coins)	In-Ntwk DED (No Coins)
Physician Office Visit		
In-Network Family Physician or Specialist	DED	DED
Out-of-Network Provider	DED + 20%	DED + 20%
Emergency Room Facility Services (per visit)		
In-Network	DED	DED
Out-of-Network	OON DED (No Coins)	OON DED (No Coins)
Provider Services at Locations other than Hospital and ER		
In-Network Family Physician	DED	DED
In-Network Specialist	DED	DED
Out-of-Network Provider	DED + 20%	DED + 20%
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Family Physician	DED	DED

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)
In-Network Specialist	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Birthing Center		
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Diabetic Equipment and Supplies*		
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum	No Maximum
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Home Health Care BPM	20 Visits	20 Visits
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Hospice LTM	No Maximum	No Maximum
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days	60 Days
In-Network	DED	DED
Out-of-Network	DED + 20%	DED + 20%
PRESCRIPTION DRUGS		
Deductible		
In-Network		
Retail (30 Days)	100% after IN DED	100% after IN DED
Generic/Preferred Brand/Non-Preferred		
Mail Order (90 Days)	100% after IN DED	100% after IN DED
Generic/Preferred Brand/Non-Preferred		
Out-of-Network		
Retail (30 Days)	50% after IN DED	50% after IN DED
Generic/Preferred Brand/Non-Preferred		
Mail Order (90 Days)	50% after IN DED	50% after IN DED
Generic/Preferred Brand/Non-Preferred		
Medical Pharmacy (Provider-Administered Rx)**		
In-Network	See Location of Service	See Location of Service
Out-of-Network	See Location of Service	See Location of Service

* 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; only office cost share applies.

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

Hmo Plan

Employee: 576.02
Add'l Spouse: 795.96
Add'l Children: 499.80
Family: 1,128.81

EE: 728.17
Spouse: 990.64
Children: 622.31
Family: 1,405.12