2016-2017 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 **Maximums shown are Per Benefit Period (BPM) unless noted**	**BlueOptions** Lower Cost 05901
Deductible (DED) (Per Person/Family Agg)	
In-Network	$2,000 / $6,000
Out-of-Network	Combined with In-Network
Coinsurance (Member Responsibility)	
In-Network	50%
Out-of-Network	50%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins & Copays
In-Network	$6,350 / $12,700
Out-of-Network	$12,800 / $25,600
Lifetime Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES	
Allergy Injections	
In-Network Family Physician	$10
In-Network Specialist	DED + 50%
Out-of-Network	DED + 50%
E-Office Visit Services	
In-Network Family Physician	$10
In-Network Specialist	$10
Out-of-Network	DED + 50%
Office Services	
In-Network Family Physician	$35 FP
In-Network Specialist	$75 SP
Out-of-Network	DED + 50%
Provider Services at Hospital and ER	
In-Network Family Physician	DED + 50%
In-Network Specialist	DED + 50%
Out-of-Network	DED + 50%
Provider Services at Other Locations	
In-Network Family Physician	DED + 50%
In-Network Specialist	DED + 50%
Out-of-Network	DED + 50%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center	
In-Network Specialist	DED + 50%
Out-of-Network	DED + 50%
PREVENTIVE CARE	
Adult Wellness Office Services	
In-Network Family Physician	$0
In-Network Specialist	$0
Out-of-Network	50% (No DED)
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies
In-Network	$0
Out-of-Network	$0
Independent Clinical Lab	
In-Network	$0
Out-of-Network	50% (No DED)
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)	

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Lower Cost 05901
In-Network - Advanced Imaging Services (AIS)	$0
In-Network - Other Diagnostic Services	$0
Out-of-Network	50% (No DED)
Mammograms (Routine and Dx)	
In-Network	$0
Out-of-Network	$0
Outpatient Hospital (per visit)	
In-Network	$0
Out-of-Network	50% (No DED)
Provider Services at Outpatient Facility	
In-Network Family Physician	$0
In-Network Specialist	$0
Out-of-Network	50% (No DED)
Well Child Office Visits (No BPM)	
In-Network Family Physician	$0
In-Network Specialist	$0
Out-of-Network	50% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE	
Ambulance Maximum (per Day)	$5,500
In-Network	DED + 50%
Out-of-Network	DED + 50%
Convenient Care Centers (CCC)	
In-Network	$35 FP
Out-of-Network	DED + 50%
Emergency Room Facility Services (also see Professional Provider Services)	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Urgent Care Centers (UCC)	
In-Network	$75 SP
Out-of-Network	$75 SP
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.	
Ambulatory Surgical Center	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Independent Clinical Lab	
In-Network	$0
Out-of-Network	DED + 50%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)	
In-Network - Advanced Imaging Services (AIS)	$200
In-Network - Other Diagnostic Services	$50
Out-of-Network	DED + 50%
Inpatient Hospital (per admit)	
In-Network	Option 1 - $2000 Option 2 - $3000
Out-of-Network	DED + 50%
Out-of-Network (Emergency Admission)	DED + 50%
Inpatient Rehab Maximum	21 Days
Outpatient Hospital (per visit)	
In-Network	Option 1 - $300 Option 2 - $400
Out-of-Network	DED + 50%
Therapy at Outpatient Hospital	
In-Network	Option 1 - $80 Option 2 - $90
Out-of-Network	DED + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Hospitalization	
In-Network	Option 1 - $2000 Option 2 - $3000
Out-of-Network	DED + 50%
Out-of-Network (Emergency Admission)	DED + 50%
Outpatient Hospitalization (per visit)	
In-Network	Option 1 - $300 Option 2 - $400
Out-of-Network	DED + 50%
Provider Services at Hospital and ER	
In-Network Family Physician or Specialist	DED + 50%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Lower Cost 05901
Out-of-Network Provider	DED + 50%
Physician Office Visit	
In-Network Family Physician or Specialist	$35 FP/ $75 SP
Out-of-Network Provider	DED + 50%
Emergency Room Facility Services (per visit)	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Provider Services at Locations other than Hospital and ER	
In-Network Family Physician	DED + 50%
In-Network Specialist	DED + 50%
Out-of-Network Provider	DED + 50%
OTHER SPECIAL SERVICES AND LOCATIONS	
Advanced Imaging Services in Physician's Office	
In-Network Family Physician	DED + 50%
In-Network Specialist	DED + 50%
Out-of-Network	DED + 50%
Birthing Center	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Diabetic Equipment and Supplies*	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Durable Medical Equipment, Prosthetics, Orthotics BPM	
In-Network	DED + 50%
Out-of-Network	DED + 50%
Home Health Care BPM	20 Visits
In-Network	DED + 50%
Out-of-Network	DED + 50%
Hospice LTM	No Max
In-Network	DED + 50%
Out-of-Network	DED + 50%
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days
In-Network	DED + 50%
Out-of-Network	DED + 50%
PRESCRIPTION DRUGS	
Deductible	
In-Network	
Retail (30 Days)	
Generic/Preferred Brand/Non-Preferred	$10/ $60/ $100
Mail Order (90 Days)	
Generic/Preferred Brand/Non-Preferred	$30/ $180/ $300
Out-of-Network	
Retail (30 Days)	
Generic/Preferred Brand/Non-Preferred	50% of allowance
Mail Order (90 Days)	
Generic/Preferred Brand/Non-Preferred	50% of allowance
Medical Pharmacy (Provider-Administered Rx)**	
In-Network	20% coinsurance
Out-of-Network	DED + 50%

***** Prescription Drug Benefit for these plans include:**
Mandatory Generics, Responsible RX Program (Step and Quantity Therapy)

NDC (National Drug Code) Lockout List

Mail Order 3 times retail copay

* 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.

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.