

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.

BlueCare 55	
COST SHARING	
Maximums shown are Per Benefit Period (BPM) unless noted	
Deductible (DED) (Per Person/Family Agg)	Not Applicable
In-Network	
Out-of-Network	
Coinsurance (Member Responsibility)	Not Applicable
In-Network	
Out-of-Network	
Out of Pocket Maximum (Per Person/Family Agg)	Includes all Copays (including Rx)
In-Network	\$1,500 / \$3,000
Out-of-Network	Not Applicable
Lifetime Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES	
Allergy Injections	
In-Network Family Physician	\$5
In-Network Specialist	\$5
Out-of-Network	Not Covered
E-Office Visit Services	
In-Network Family Physician	\$10 PCP
In-Network Specialist	\$10 SP
Out-of-Network	Not Covered
Office Services	
In-Network Family Physician	\$10 PCP
In-Network Specialist	\$10 SP
Out-of-Network	Not Covered
Provider Services at Hospital and ER	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	Not Covered
Provider Services at Other Locations	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	Not Covered
Radiology, Pathology and Anesthesiology	
Provider Services at Hospital or Ambulatory Surgical Center	
In-Network Specialist	\$0
Out-of-Network	Not Covered
PREVENTIVE CARE	
Adult Wellness Office Services	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	Not Covered
Colonoscopies (Routine)	
In-Network	Age 50+ then Frequency Schedule Applies
Out-of-Network	\$0
	Not Covered
Mammograms (Routine and Dx)	
In-Network	\$0
Out-of-Network	Not Covered
Well Child Office Visits (No BPM)	
In-Network Family Physician	\$0
In-Network Specialist	\$0
Out-of-Network	Not Covered

COST SHARING		BlueCare
Maximums shown are Per Benefit Period (BPM) unless noted		55
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance Maximum (per Day)		No Maximum
In-Network		\$0
Out-of-Network		Not Covered
Convenient Care Centers (CCC)		
In-Network		\$10 PCP
Out-of-Network		Not Covered
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network		\$50
Out-of-Network		\$50
Urgent Care Centers (UCC)		
In-Network		\$10 SP
Out-of-Network		\$10 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		\$100
Out-of-Network		Not Covered
Independent Clinical Lab		
In-Network		\$0
Out-of-Network		Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS)		\$0
In-Network - Other Diagnostic Services		\$0
Out-of-Network		Not Covered
Inpatient Hospital (per admit)		
In-Network		\$250
Out-of-Network		Not Covered
Inpatient Rehab Maximum		No Maximum
Outpatient Hospital (per visit)		
In-Network		\$100
Out-of-Network		Not Covered
Therapy at Outpatient Hospital		
In-Network		\$5
Out-of-Network		Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization (30 day max)		
In-Network		\$250
Out-of-Network		Not Covered
Outpatient Hospitalization (per visit)		
In-Network		\$10
Out-of-Network		Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist		\$0
Out-of-Network Provider		Not Covered
Physician Office Visit		
In-Network Family Physician or Specialist		\$10
Out-of-Network Provider		Not Covered
Emergency Room Facility Services (per visit)		
In-Network		\$50
Out-of-Network		\$50
Provider Services at Locations other than Hospital and ER		
In-Network Family Physician		\$0
In-Network Specialist		\$0
Out-of-Network Provider		Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Family Physician		\$0
In-Network Specialist		\$0
Out-of-Network		Not Covered
Birthing Center		
In-Network		\$0
Out-of-Network		Not Covered
Diabetic Equipment and Supplies*		
In-Network		\$0
Out-of-Network		Not Covered

BlueCare 55	
COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum
In-Network	\$0
Out-of-Network	Not Covered
Home Health Care BPM	No Maximum
In-Network	\$0
Out-of-Network	Not Covered
Hospice LTM	No Maximum
In-Network	\$0
Out-of-Network	Not Covered
Outpatient Therapy and Spinal Manipulations BPM	62 visits. Auth Req for Therapy
Skilled Nursing Facility BPM	90 Days
In-Network	\$0
Out-of-Network	Not Covered
PRESCRIPTION DRUGS	
Deductible	
In-Network	
Retail (30 Days)	\$5/ \$25/ \$25
Generic/Preferred Brand/Non-Preferred	
Mail Order (90 Days)	\$10 /\$50/ \$50
Generic/Preferred Brand/Non-Preferred	
Out-of-Network	
Retail (30 Days)	Not Applicable
Generic/Preferred Brand/Non-Preferred	
Mail Order (90 Days)	
Generic/Preferred Brand/Non-Preferred	
Medical Pharmacy (Provider-Administered Rx)**	
In-Network	See Location of Service
Out-of-Network	Not Covered

* 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.