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	BlueCare 59
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	$15
In-Network Specialist	$35
Out-of-Network	Not Covered
Office Services	
In-Network Family Physician	$15 PCP
In-Network Specialist	$35 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)	Age 50+ then Frequency Schedule Applies
In-Network	$0
Out-of-Network	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

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare 59
Out-of-Network	Not Covered
EMERGENCY/URGENT/CONVENIENT CARE	
Ambulance Maximum (per Day)	No Maximum
In-Network	$0
Out-of-Network	Not Covered
Convenient Care Centers (CCC)	
In-Network	$15 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	$35
Out-of-Network	$35
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	$200
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	$150 per Day up to $750
Out-of-Network	Not Covered
Inpatient Rehab Maximum	No Maximum
Outpatient Hospital (per visit)	
In-Network	$200
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 maximum)	
In-Network	$150 per day up to $750
Out-of-Network	Not Covered
Outpatient Hospitalization (per visit)	
In-Network	$35
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	$15 FP/ $35 SP
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

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare 59
Out-of-Network	Not Covered
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)	$10/ $25/$60
Generic/Preferred Brand/Non-Preferred	
Mail Order (90 Days)	$20 /$50/$120
Generic/Preferred Brand/Non-Preferred	
Out-of-Network	
Retail (30 Days)	
Generic/Preferred Brand/Non-Preferred	Not Applicable
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.