# 2013 Benefit Summary

| COST SHARING | BlueCare HMO 48 | BlueOptions (PPO) 05782 | BlueCare HDHP 65 |
|---|---|---|---|
| **Deductible (DED) (Per Person/Family Aggregate)**<br>• In-Network<br>• Out-of-Network | $300 / $600<br>Not Covered | $750 / $1,500<br>$1,000 / $2,000 | $1,500 / $3,000<br>Not Covered |
| **Coinsurance (Member Responsibility)**<br>• In-Network<br>• Out-of-Network | 30%<br>Not Applicable | 30%<br>50% | 30%<br>Not Applicable |
| **Out of Pocket Maximum (Per Person/Family Aggregate)**<br>Includes DED, Coins and all Copays (Excludes Rx)<br>• In-Network<br>• Out-of-Network | $2,500 / $5,000<br>Not Applicable | $6,000 / $12,000<br>$9,000 / $18,000 | $5,000 / $10,000<br>Not Covered |
| **Lifetime Maximum** | No Maximum | No Maximum | No Maximum |
| **PROFESSIONAL PROVIDER SERVICES** | | | |
| **Office Services** (including Allergy injections, treatment & testing)<br>• In-Network Family Physician / Specialist<br>• Out-of-Network | $25 / $35<br>Not Covered | $30 / $40<br>DED + 50% | $25 / DED + 30%<br>Not Covered |
| **Provider Services at Hospital and Emergency Room**<br>• In-Network Family Physician or Specialist<br>• Out-of-Network | DED + 30%<br>Hospital: Not Covered<br>ER: In-Network DED + 30% | DED + 30%<br>Hospital: DED + 50%<br>ER: In-Network DED + 30% | DED + 30%<br>Hospital: Not Covered<br>ER: In-Network DED + 30% |
| **Provider Services at ASC**<br>• In-Network Family Physician / Specialist<br>• Out-of-Network | $25 / $35<br>Not Covered | $30 / $40<br>DED + 50% | DED + 30%<br>Not Covered |
| **Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center**<br>• In-Network Family Physician / Specialist<br>• Out-of-Network | $30<br>Not Covered | $35<br>DED + 50% | DED + 30%<br>Not Covered |
| **PREVENTIVE CARE** | | | |
| **Adult & Child Wellness Office Services**<br>• In-Network Family Physician or Specialist<br>• Out-of-Network | $0<br>Not Covered | $0<br>50% (No DED) | $0<br>Not Covered |
| **Colonoscopies (for age 50+ then frequency schedule applies)**<br>• In-Network<br>• Out-of-Network | $0<br>Not Covered | $0<br>$0 | $0<br>Not Covered |
| **Mammograms**<br>• In-Network<br>• Out-of-Network | $0<br>Not Covered | $0<br>$0 | $0<br>Not Covered |
| **EMERGENCY/URGENT/CONVENIENT CARE** | | | |
| **Ambulance**<br>• In-Network & Out-of-Network | $200 | $200 | DED + 30% |
| **Convenient Care Centers (CCC)**<br>• In-Network<br>• Out-of-Network | $25<br>Not Covered | $30<br>DED + 50% | DED + 30%<br>Not Covered |
| **Emergency Room Facility Services**<br>• In-Network<br>• Out-of-Network | $300 + 30%<br>$300 + 30% | $300 + 30%<br>$300 + 30% | DED + 30%<br>In-Network DED + 30% |
| **Urgent Care Centers (UCC)**<br>• In-Network<br>• Out-of-Network | $30<br>Not Covered | $35<br>DED + 50% | $25<br>Not Covered |

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| **FACILITY SERVICES - HOSP/SURG/ICL/IDTF** | | | |
| **Ambulatory Surgical Center**<br>• In-Network<br>• Out-of-Network | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>DED + 50% | <br>DED + 30%<br>Not Covered |
| **Independent Clinical Lab**<br>• In-Network<br>• Out-of-Network | <br>$0<br>Not Covered | <br>$0<br>DED + 50% | <br>$0<br>Not Covered |
| **Independent Diagnostic Testing Facility - X-rays and AIS (Includes Physician Services)**<br>• In-Network - Advanced Imaging Services (AIS)<br>• In-Network - Other Diagnostic Services<br>• Out-of-Network | <br>$300<br>$30<br>Not Covered | <br>$300<br>$35<br>DED + 50% | <br>DED + 30%<br>DED + 30%<br>Not Covered |
| **Inpatient Hospital (per admit)**<br>• In-Network<br>• Out-of-Network | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>DED + 50% | <br>DED + 30%<br>Not Covered |
| **Inpatient Rehab Maximum** | 21 Days | 21 Days | 21 Days |
| **Outpatient Hospital (per visit)**<br>• In-Network<br>• Out-of-Network | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>DED + 50% | <br>DED + 30%<br>Not Covered |
| **MENTAL HEALTH AND SUBSTANCE ABUSE** | | | |
| **Inpatient Hospitalization**<br>• In-Network<br>• Out-of-Network | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>DED + 50% | <br>DED + 30%<br>Not Covered |
| **Outpatient Hospitalization (per visit)**<br>• In-Network<br>• Out-of-Network | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>DED + 50% | <br>DED + 30%<br>Not Covered |
| **Provider Services at Hospital and Emergency Room**<br>• In-Network Family Physician or Specialist<br>• Out-of-Network Provider | <br>30% (includes ER OON)<br>Hospital: Not Covered | <br>30% (includes ER OON)<br>30% | <br>DED + 30% (includes ER OON)<br>Hospital: Not Covered |
| **Physician Office Visit**<br>• In-Network Family Physician or Specialist<br>• Out-of-Network Provider | <br>$25/$35<br>Not Covered | <br>$30/$40<br>DED + 50% | <br>$25/DED + 30%<br>Not Covered |
| **Emergency Room Facility Services (per visit)**<br>• In-Network<br>• Out-of-Network | <br>$300 + 30%<br>$300 + 30% | <br>$300 + 30%<br>$300 + 30% | <br>DED + 30%<br>In-Network DED + 30% |
| **Provider Services at Locations other than Hospital/ER**<br>• In-Network Family Physician or Specialist<br>• Out-of-Network Provider | <br>DED + 30%<br>Not Covered | <br>DED + 30%<br>50% (No DED) | <br>DED + 30%<br>Not Covered |
| **OTHER SPECIAL SERVICES AND LOCATIONS** | | | |
| **Skilled Nursing Facility**<br>• In-Network Physician Services<br>• Out-of-Network | INN Facility DED+30%<br>$25/$35<br>Not Covered | INN Facility DED+30%<br>$30/$40<br>DED + 50% | INN Facility DED+30%<br>DED + 30%<br>Not Covered |
| **Combined Outpatient Cardiac Rehabilitation & Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations**<br>• In-Network<br>• Out-of-Network | 60 Visits/20 Manipulations<br>Auth Required for Therapy<br>$35<br>Not Covered | 60 Visits/20 Manipulations<br>Auth Required for Therapy<br>$40<br>DED + 50% | 60 Visits/20 Manipulations<br>Auth Required for Therapy<br>DED + 30%<br>Not Covered |
| **Durable Medical Equipment, Prosthetics, Orthotics**<br>• In-Network – Motorized Wheelchair<br>• In-Network – All Other<br>• Out-of-Network | $500<br>$30<br>Not Covered | $500<br>$45<br>DED + 50% | $500<br>DED + 30%<br>Not Covered |

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| **OTHER SPECIAL SERVICES AND LOCATIONS CONT** | | | |
| **Home Health Care**<br>• In-Network<br>• Out-of-Network | $20<br>Not Covered | $20<br>DED + 50% | DED + 30%<br>Not Covered |
| **Hospice**<br>• In-Network (Office Visit)<br>• In-Network (Inpatient Facility)<br>• Out-of-Network | $20<br>DED + 30%<br>Not Covered | $20<br>DED + 30%<br>DED + 50% | DED + 30%<br>DED + 30%<br>No Covered |
| **PRESCRIPTION DRUGS – IN-NETWORK** | | | |
| **Retail (30 days)**<br>• Generic/Preferred Brand/Non-Preferred<br>**Mail Order (90 days)**<br>• Generic/Preferred Brand/Non-Preferred | $10 / $40 / $75<br><br>$20 / $80 / $150 | $10 / $40 / $75<br><br>$20 / $80 / $150 | $10 / $40 / $75<br><br>$20 / $80 / $150 |

*Diabetic Supplies (lancets, strips, etc.) obtained under the Rx benefit would be paid at 100% (no cost to member). Diabetic Supplies obtained through a participating DME vendor, would be processed under medical and paid at 100% (no cost to member).*

*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.*

*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.*

| IMPORTANT NUMBERS & HOURS OF OPERATION | | |
|---|---|---|
| **Contact:** | **Phone Number** | **Hours of Operation** |
| **Florida Blue Customer Service**<br>(Medical and Pharmacy Inquiries) | 1-800-664-5295 | Monday – Thursday 8am – 6pm<br>Friday 9am – 6pm |
| **PrimeMail**<br>(Mail Order Prescriptions) | 1-888-849-7865 | 24/7 |
| **Caremark Specialty Pharmacy**<br>(Specialty Medication Pharmacy) | 1-866-278-5108 | 6:30am to 8pm |
| **CareCentrix**<br>(Durable Medical Equipment) | 1-877-561-9910 | Monday – Thursday 8am-8pm<br>Friday 8am – 6pm |