MONROE COUNTY BOCC BENEFIT SUMMARIES EFFCTIVE 1/1/2018

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** HSA Compatible 05182 (Single Coverage)	**BlueOptions** HSA Compatible 05183 (Family Coverage)	**BlueOptions** Predictable Cost 03559
Deductible (DED) **(Per Person/Family Agg)** In-Network Out-of-Network	 $2, 000 / Not Applicable Combined with In-network **Applies to Pharmacy Benefits**	 $4,000 / $4,000 Combined with In-network **Applies to Pharmacy Benefits**	 $400 / $800 Combined with In-network
Coinsurance (Member Responsibility) In-Network Out-of-Network	 20% 50%	 20% 50%	 25% 55%
Out of Pocket Maximum **(Per Person/Family Agg)** In-Network Out-of-Network	Includes DED, Coins, PAD and PVD. $6,650/ Not Applicable Combined with In-Network	Includes DED, Coins, PAD and PVD. $13, 300 / $13,300 Combined with In-Network	Includes DED, Coins, PAD, PVD and Copays. $7,150 / $14,300 Combined with In-Network
Lifetime Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% DED + 50%	 DED + 20% DED + 20% DED + 50%	 $10 Copay $10 Copay DED + 55%
E-Office Visit Services In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% DED + 50%	 DED + 20% DED + 20% DED + 50%	 $10 Copay $10 Copay DED + 55%
Office Services In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% DED + 50%	 DED + 20% DED + 20% DED + 50%	 $30 Copay $50 Copay DED + 55%
Maternity Office Services In Network Specialist Out-of-Network	 DED + 20% DED + 50%	 DED + 20% DED + 50%	 $30 Copay DED + 55%
Provider Services at Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% INN DED + 20%	 DED + 20% DED + 20% INN DED + 20%	 DED + 25% DED + 25% INN DED + 25%
Provider Services at Other Locations In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% DED + 50%	 DED + 20% DED + 20% DED + 50%	 DED + 25% DED + 25% DED + 55%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center In-Network Specialist Out-of-Network	 DED + 20% INN DED + 20%	 DED + 20% INN DED + 20%	 DED + 25% DED + 55%
PREVENTIVE CARE			
Adult Wellness Office Services In-Network Family Physician/ Specialist Out-of-Network	 $0 50% (No DED)	 $0 50% (No DED)	 $0 55% (No DED)
Colonoscopies (Routine) In-Network Out-of-Network	Age 50+ then Frequency Schedule Applies $0 $0	Age 50+ then Frequency Schedule Applies $0 $0	Age 50+ then Frequency Schedule Applies $0 $0
Mammograms (Routine) In-Network Out-of-Network	 $0 $0	 $0 $0	 $0 $0
Well Child Office Visits In-Network Family Physician In-Network Specialist Out-of-Network	 $0 $0 50% (No DED)	 $0 $0 50% (No DED)	 $0 $0 55% (No DED)
AMBULANCE/ URGENT CARE /CONVENIENT CARE			
Ambulance Maximum (per day) In-Network Out-of-Network	**No Maximum** DED + 20% INN DED + 20%	**No Maximum** DED + 20% INN DED + 20%	**No Maximum** DED + 25% INN DED + 25%

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Convenient Care Centers (CCC)			
In-Network	DED + 20%	DED + 20%	$25 Copay
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Urgent Care Centers (UCC)			
In-Network	DED + 20%	DED + 20%	$50 Copay
Out-of-Network	DED + 50%	DED + 50%	DED + $50 Copay
FACILITY SERVICES – HOSPITAL /SURGICAL / LAB/ INDEPENDENT DIAGNOSTIC TESTING FACILITY			
Ambulatory Surgical Center			
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	INN DED + 25%
Independent Clinical Lab			
In-Network	DED	DED	$10 Copay
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	DED + 20%	DED + 20%	DED + 25%
In-Network - Other Diagnostic Services	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Emergency Room Facility Services			
In-Network	DED + 20%	DED + 20%	$300 PVD + DED + 25%
Out-of-Network	DED + 20%	DED + 20%	$300 PVD + DED + 25%
Inpatient Hospital (per admit)			
In-Network – Option 1	DED + 20%	DED + 20%	$150 PAD + DED + 25%
In-Network—Option 2	DED + 20%	DED + 20%	$150 PAD + DED + 25%
Out-of-Network	DED + 50%	DED + 50%	$150 PAD + DED + 55%
Inpatient Rehab Maximum	**30 Days**	**30 Days**	**30 Days**
Outpatient Hospital (per visit)			
In-Network – Option 1	DED + 20%	DED + 20%	DED + 25%
In-Network—Option 2	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Therapy at Outpatient Hospital			
In-Network—Option 1	DED + 20%	DED + 20%	DED + 25%
In-Network—Option 2	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Therapy at Free Standing Facility			
In-network-Free Standing Facility	DED + 20%	DED + 20%	DED + 25%
In-Network- Specialist Office			$50 Copay
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Hospitalization			
In-Network – Option 1	DED + 20%	DED + 20%	$150 PAD + DED + 25%
In-Network – Option 2			$150 PAD + DED + 25%
Out-of-Network	DED + 50%	DED + 50%	$150 PAD + DED + 55%
Outpatient Hospitalization (per visit)			
In-Network – Option 1			DED + 25%
In-Network – Option 2			DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%)
Provider Services at Hospital and ER			
In-Network Family Physician or Specialist	DED + 20%	DED + 20%	DED + 25%
Out-of-Network Provider	INN DED + 20%	INN DED + 20%	DED + 25%
Physician Office Visit			
In-Network Family Physician or Specialist	DED + 20%	DED + 20%	$30 Copay
Out-of-Network Provider	DED + 50%	DED + 50%	DED + 55%
Emergency Room Facility Services (per visit)			
In-Network	DED + 20%	DED + 20%	$300 PVD + DED + 25%
Out-of-Network	INN DED + 20%	INN DED + 20%	$300 PVD + DED + 25%
Provider Services at Locations other than Office Hospital or ER			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 25%
In-Network Specialist	DED + 20%	DED + 20%	DED + 25%
Out-of-Network Provider	DED + 50%	DED + 50%	DED + 55%

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OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Family Physician	DED + 20%	DED + 10%	DED + 25%
In-Network Specialist	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Birthing Center			
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Diabetic Equipment			
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Durable Medical Equipment, Prosthetics, Orthotics	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Enteral Formula BPM	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Home Health Care BPM	**40 Visits**	**40 Visits**	**40 Visits**
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Hospice	**No Maximum**	**No Maximum**	No Maximum
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Outpatient Therapy and Spinal Manipulations BPM	**50 Visits (Includes up to 26 Spinal Manipulations)**	**50 Visits (Includes up to 26 Spinal Manipulations)**	**50 Visits (Includes up to 26 Spinal Manipulations)**
Skilled Nursing Facility BPM	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 20%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 55%
Telemedicine / Teladoc			
In-Network	$40 Copay	$40 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	Not Covered
Medical Pharmacy (Provider-Administered Rx)**	**$200 Monthly OOP Max Applies after DED**	**$200 Monthly OOP Max Applies after DED**	**$200 Monthly OOP Max**
In-Network	DED + 20% DED + 50%	DED + 20% DED + 50%	20%(No DED)
Out-of-Network			DED + 50%
PRESCRIPTION DRUGS – PROVIDED BY ENVISION			
Deductible	**Medical (05182/ 05183) DED Must be met before RX copays apply**		
In-Network (Retail 30 Days) Generic/Preferred Brand/Non-Preferred	$15 / $50 / $90		
Mail Order (90 days) Generic/Preferred Brand/Non-Preferred	$37.50 / $125 / $225		
Specialty Meds- Generic / Preferred Brand/ Non-Preferred	20% with $250 Maximum / 20% with $250 Maximum / 20% with $250 Maximum		
NOTE:	Effective 1/1/18, over the counter (OTC) medications will no longer be available through the prescription plan. All maintenance medications (ex: diabetes meds, hbp) will require a 90 day supply at retail. Walgreens is the exclusive retail pharmacy you must use for the 90 day maintenance medication prescriptions. Mail Order Pharmacy: Envision Mail #" 866-909-5170, NABP: 3677361 Specialty Pharmacy: Costco Specialty #:866-443-0060, NABP: 5635670 See Select formulary information online at envisionrx.com		

** (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 injections or immunizations; only office cost share applies.

RX Copay Exceptions: Diabetic Med/Supplies: $10 for 30 Days or $25 for 90 Days.

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.

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.