Benefit Summaries

Monroe County BOCC -Effective 01/01/2020

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** Plan 03559	**BlueOptions** Plan 03769 Retirees	**BlueOptions** HSA-Compatible 05182 (Single Coverage)	**BlueOptions** HSA-Compatible 05183 (Family Coverage)
Deductible (DED) (Per Person/Family Agg)				
In-Network	$400 / $800	$400 / N/A	$2,000 / Not Applicable	$4,000 / $4,000
Out-of-Network	Combined with INN	Combined with INN	Combined with INN **Applies to Pharmacy Benefits**	Combined with INN **Applies to Pharmacy Benefits**
Coinsurance (Member Responsibility)				
In-Network	25%	25%	20%	20%
Out-of-Network	55%	55%	50%	50%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins ,PAD, PVD and Copays	Includes DED, Coins, PAD, PVD and Copays	Includes DED, Coins, PAD & PVD	Includes DED, Coins, PAD & PVD
In-Network	$7,150 / $14,300	$3,575 / N/A	$6,650 / Not Applicable	$13,000 / $13,000
Out-of-Network	Combined with INN	Combined with INN	Combined with INN	Combined with INN
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES				
Allergy Injections				
In-Network Family Physician / Specialist	$10 Copay / $10 Copay	$10 Copay / $10 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
E-Office Visit Services				
In-Network Family Physician /Specialist	$10 Copay / $10 Copay	$10 Copay / $10 Copay	DED + 20% / DED + 20%	DED + 20% / DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Office Services				
In-Network Family Physician	$30 Copay	$30 Copay	DED + 20%	DED + 20%
In-Network Specialist	$50 Copay	$50 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Maternity Office Services				
In-Network Specialist	$30 Copay	$30 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Advanced Imaging Services in Physician's Office				
In-Network Family Physician	DED + 25%	DED + 25%	DED + 20%	DED + 20%
In-Network Specialist	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Diagnostics - X-ray in Physician's office				
In-Network Family Physician	DED + 25%	DED + 25%	DED + 20%	DED + 20%
In-Network Specialist	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Provider Services at ER				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 25%	INN DED + 25%	INN DED + 20%	INN DED + 20%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** Plan 03559	**BlueOptions** Plan 03769 Retirees	**BlueOptions** HSA-Compatible 05182 (Single Coverage)	**BlueOptions** HSA-Compatible 05183 (Family Coverage)
Provider Services at Hospital				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 25%	INN DED + 25%	INN DED + 20%	INN DED + 20%
Radiology, Pathology and Anesthesiology Provider Services at Hospital				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 25%	INN DED + 25%	INN DED + 20%	INN DED + 20%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Ctr				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 25%	INN DED + 25%	INN DED + 20%	INN DED + 20%
Provider Services at Other Locations				
In-Network Family Physician /Specialist	DED + 25%	DED + 25%	DED + 20% / DED + 20%	DED + 20% / DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
PREVENTIVE CARE				
Adult Wellness Office Services				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	55%	55%	50%	50%
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0
Mammograms (Routine)				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0
Well Child Office Visits (No BPM)				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	55%	55%	50%	50%
EMERGENCY/ URGENT/ CONVENIENT CARE				
Ambulance Maximum (per day)	**No Maximum**	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 25%	INN DED + 25%	INN DED + 20%	INN DED + 20%
Convenient Care Centers (CCC)				
In-Network	$25 Copay	$25 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Emergency Room Facility Services (Waived if Admitted)				
In-Network	$300 PVD + DED + 25%	$300 PVD + DED + 25%	DED + 20%	DED + 20%
Out-of-Network	$300 PVD + DED + 25%	$300 PVD + DED + 25%	DED + 20%	DED + 20%
Urgent Care Centers (UCC)				
In-Network	$50 Copay	$50 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + $50 Copay	DED + $50 Copay	DED + 20%	DED + 20%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Plan 03559	BlueOptions Plan 03769 Retirees	BlueOptions HSA-Compatible 05182 (Single Coverage)	BlueOptions HSA-Compatible 05183 (Family Coverage)
FACILITY SERVICES – HOSPITAL / SURGICAL / LAB / INDEPENDENT DIAGNOSTIC TESTING FACILITY				
Ambulatory Surgical Center				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Independent Clinical Lab				
In-Network	$10 Copay	$10 Copay	DED	DED
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)				
In-Network - Advanced Imaging Services (AIS)	DED + 25%	DED + 25%	DED + 20%	DED + 20%
In-Network - Other Diagnostic Services	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Diagnostic Services at Outpatient Hospital				
Advanced Imaging	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Other Diagnostic Services	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Inpatient Hospital (Per Admit)				
In-Network –Option 1	$150 PAD + DED + 25%	$150 PAD + DED + 25%	DED + 20%	DED + 20%
In-Network—Option 2	$150 PAD + DED + 25%	$150 PAD + DED + 25%	DED + 20%	DED + 20%
Out-of-Network	$150 PAD + DED + 55%	$150 PAD + DED + 55%	DED + 50%	DED + 50%
Inpatient Rehab Maximum	**30 Days**	**30 Days**	**30 Days**	**30 Days**
Outpatient Hospital (per visit)				
In-Network –Option 1	DED + 25%	DED + 25%	DED + 20%	DED + 20%
In-Network –Option 2	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Therapy at Outpatient Hospital				
In-Network—Option 1	$30 + DED	$100 Copay	DED + 20%	DED + 20%
In-Network –Option 2	$30 + DED		DED + 20%	DED + 20%
Out-of-Network	DED + 55%	55%	DED + 50%	DED + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Hospitalization (Per Admit)				
In-Network—Option 1	$150 PAD + DED + 25%	$150 PAD + DED + 25%	DED + 20%	DED + 20%
In-Network—Option 2	$150 PAD + DED + 25%	$150 PAD + DED + 25%	DED + 20%	DED + 20%
Out-of-Network	$150 PAD + DED + 55%	$150 PAD + DED + 55%	INN DED + 20%	INN DED + 20%
Outpatient Hospitalization (per visit)				
In-Network—Option 1	DED + 25%	DED + 25%	DED + 20%	DED + 20%
In-Network—Option 2	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Provider Services at Hospital				
In-Network Family Physician or Specialist	DED + 25% / DED + 25%	DED + 25% / DED + 25%	DED + 20%	DED + 20%
Out-of-Network Provider	DED + 25%	DED + 25%	INN DED + 20%	INN DED + 20%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** Plan 03559	**BlueOptions** Plan 03769 Retirees	**BlueOptions** HSA-Compatible 05182 (Single Coverage)	**BlueOptions** HSA-Compatible 05183 (Family Coverage)
Provider Services at ER				
In-Network Family Physician / Specialist	DED + 25% / DED + 25%	DED + 25% / DED + 25%	DED + 20%	DED + 20%
Out-of-Network Provider	DED + 25%	DED + 25%	INN DED + 20%	INN DED + 20%
Physician Office Visit				
In-Network Family Physician / Specialist	$30 Copay / $30 Copay	$30 Copay / $30 Copay	DED + 20% / DED + 20%	DED + 20% / DED + 20%
Out-of-Network Provider	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Emergency Room Facility Services (per visit)				
In-Network	$300 PVD + DED + 25%	$300 PVD + DED + 25%	DED + 20%	DED + 20%
Out-of-Network	$300 PVD + DED + 25%	$300 PVD + DED + 25%	INN DED + 20%	INN DED + 20%
Provider Services at Locations other than Hospital and ER				
In-Network Family Physician / Specialist	DED + 25% / DED + 25%	DED + 25% / DED + 25%	DED + 20% / DED + 20%	DED + 20% / DED + 20%
Out-of-Network Provider	DED + 55%	DED + 55%	DED + 50%	DED + 50%
OTHER SPECIAL SERVICES AND LOCATIONS				
Birthing Center				
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
***Durable Medical Equipment**	**No Maximum**	**No Maximum**	**No Maximum**	**No Maximum**
In-Network-	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Prosthetics / Orthotics				
Prosthetics- In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Prosthetics- Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Orthotics-In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Orthotics-Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Enteral Formula	**No Maximum**	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Home Health Care BPM	**40 Visits**	**40 Visits**	**40 Visits**	**40 Visits**
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Hospice LTM	**No Maximum**	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
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)	50 Visits (Includes up to 26 Spinal Manipulations)
Therapy in Free Standing Facility	DED + 25%	DED + 25%	DED + 20%	DED + 20%
Therapy in Physician's Office	$50 Copay	$50 Copay	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%
Skilled Nursing Facility BPM	**No Maximum**	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED+ 25%	DED + 25%	DED + 20%	DED + 20%
Out-of-Network	DED + 55%	DED + 55%	DED + 50%	DED + 50%

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Medical Pharmacy (Provider Administered RX)**	**$200 Monthly OOP Max**	**$200 Monthly OOP Max**	**$200 Monthly OOP Max Applies After Deductible**	**$200 Monthly OOP Max Applies After Deductible**
In-Network	20% (No DED)	20% (No DED)	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%	DED + 50%
Telemedicine / Teladoc				
In-Network	$0 Copay	$0 Copay	$40 Copay	$40 Copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
PRESCRIPTION DRUGS—PROVIDED BY ENVISION				
Deductible	$0	$0	**Medical (0182/05183) DED Must be met before RX copays apply**	
In-Network **Retail (30 days)** Generic/Preferred Brand/Non-Preferred Specialty –Preferred /Non-Preferred **Mail Order (90 days)** Generic/Preferred Brand/Non-Preferred Specialty –Generic /Preferred /Non-Preferred	$15/ $50 / $90 $37.50 / $125 / $225 20% with $250 Max / 20% with $250 Max / 20% with $ 250 Max		$15 / $50 / $90 $37.50 / $125 / $225 20% with $250 Max / 20% with $250 Max / 20% with $ 250 Max	
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.** **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**		**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..** **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**	

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.