Mgmt proposal 10/5/11

BlueCare
For Large Groups
Health Benefit Summary Plan 52

FLORIDA
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	 $40 Copayment $65 Copayment Not Covered $10 Copayment Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) In-Network Out-of-Network	 $300 Copayment Not Covered
Maternity Initial Visit In-Network Family Physician In-Network Specialist Out-of-Network	 $40 Copayment $65 Copayment Not Covered
Allergy Injections (per visit) In-Network Out-of-Network	 $10 Copayment Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[1] In-Network Provider Out-of-Network	 $200 20% Coinsurance Not Covered
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**	
Convenient Care Centers In-Network Out-of-Network	 $40 Copayment Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations In-Network Out-of-Network	 $0 Not Covered
Mammograms In-Network Out-of-Network	 $0 Not Covered
Colonoscopy (Routine for age 50+ then frequency schedule applies) In-Network Out-of-Network	 $0 Not Covered
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 $85 Copayment Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $300 Copayment
Ambulance Services (Ground, air and water travel, combined per day maximum) In-Network and Out-of-Network	$5,000 In-Network DED[2] + 30% Coinsurance

[1] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.
[2] DED = Deductible

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Benefits for Covered Services	*Amount Member Pays*
Outpatient Diagnostic Services	
Independent Diagnostic Testing Center Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	$65 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$200 Copayment
Out-of-Network	Not Covered
Independent Clinical Lab (e.g. Blood Work)	
In-Network	$0
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)	
In-Network	DED + 30% Coinsurance
Out-of Network	Not Covered
Other Provider Services	
Provider Services at Hospital and ER	
In-Network	DED + 30% Coinsurance
Out-of-Network ER	In-Network DED + 30% Coinsurance
Out-of-Network Hospital	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network Specialist	$100 Copayment
Out-of-Network	Not Covered
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	DED + 30% Coinsurance
In-Network Specialist	DED + 30% Coinsurance
Out-of-Network	Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max)	30 Visits
Locations other than Physician's Office and Hospital	
In-Network	$65 Copayment
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network	$85 Copayment
Out-of-Network	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network – Motorized Wheelchair	$500 Copayment
In-Network – All Other	$0
Out-of-Network	Not Covered
Home Health Care (PBP Max)	60 Visits
In-Network	$0
Out-of-Network	Not Covered
Skilled Nursing Facility (PBP Max)	45 days
In-Network	DED + 30% Coinsurance
Out-of-Network	Not Covered
Hospice	
In-Network	DED + 30% Coinsurance
Out-of-Network	Not Covered
Hospital / Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	DED + 30% Coinsurance
Out-of-Network	Not Covered

[3] PBP = Per Benefit Period

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Benefits for Covered Services	*Amount Member Pays*
Hospital / Surgical (Continued)	
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 21 days DED + 30% Coinsurance Not Covered
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services In-Network – All other Services Out-of-Network	 $85 Copayment DED + 30% Coinsurance Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $300 Copayment
Mental Health / Substance Dependency	
Inpatient Hospitalization Facility Services[4] (per admit) In-Network Out-of-Network	 $0 Not Covered
Outpatient Hospitalization Facility Service (per visit) In-Network Out-of-Network	 $0 Not Covered
Emergency Room Facility Services (per visit) In-Network and Out-of-Network	 $0
Provider Services at Hospital and ER In-Network Family Physician / Specialist Out-of-Network ER Out-of-Network Hospital	 $0 $0 Not Covered
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / Specialist Out-of-Network	 $0 Not Covered
Outpatient Office Visit In-Network Family Physician / Specialist Out-of-Network	 $0 Not Covered
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before BCBSF pays)	 $1,500 / Not Applicable Not Covered
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 30% Not Covered
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	 $10,000 / $10,000 Not Covered
Total Lifetime Maximum Benefit	No Maximum

[4] Inpatient Substance Dependency Treatment is limited to Detoxification only

Additional Benefits and Features

BlueCare Rx Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Health Options, Inc., you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.bcbsfl.com*** and other interactive web-based support tools.
- **Expert advice on call.** We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- **MyBlueService** is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced **WebMD** website especially for our members only.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueCare members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

Referrals to participating providers are not required, however authorizations are required for certain medical services like hospitalization, rehabilitation services, home care, select DME, and certain office based services such as CT scans, MRIs/MRAs, cardiac nuclear medicine studies, and select injectables, etc. Additional information related to access to providers can be found in the Provider Directory. This summary is only a partial description of the many benefits and services covered by Health Options, the HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Blue Cross and Blue Shield of Florida's BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.

** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.