BCBS PLAN COMPARISON 2014

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare 41	BlueOptions Predictable Cost 3559	BlueOptions HSA Compatible 3160 (Single Coverage)	BlueOptions HSA Compatible 3161 (Family Coverage)
Deductible (DED) (Per Person/Family Agg)				
In-Network	$500/$1,000	$500 / $1,500	$1,500 / Not Applicable	$3.000 / $3,000
Out-of-Network	Not Applicable	Combined with In network	$3,500 / Not Applicable	$6,000 / $6,000
Coinsurance (Member Responsibility)				
In-Network	20%	20%	20%	20%
Out-of-Network	Not Applicable	40%	40%	40%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins and all Copays (including Rx)	Includes DED, Coins, Copays; Excludes Rx	Includes DED, Coins, Copays	Includes DED, Coins, Copays
In-Network	$2,000 / $4,000	$3,000 / $9,000	$5,000 / Not Applicable	$5,000 / $5,000
Out-of-Network	Not Applicable	Combined with In Network	$10,000 / Not Applicable	$10,000 / $10,000
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES				
Allergy Injections				
In-Network Family Physician	$5	$10	DED + 20%	DED + 20%
In-Network Specialist	$5	$10	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
E-Office Visit Services				
In-Network Family Physician	$15 PCP	$10	DED + 20%	DED + 20%
In-Network Specialist	$30 SP	$10	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Office Services				
In-Network Family Physician	$15 PCP	$15 FP	DED + 20%	DED + 20%
In-Network Specialist	$30 SP	$30 SP	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Provider Services at Hospital and ER				
In-Network Family Physician	$0	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Provider Services at Other Locations				
In-Network Family Physician	$0	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center				
In-Network Specialist	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%
PREVENTIVE CARE				
Adult Wellness Office Services				
In-Network Family Physician	$15 PCP	$15 FP	20% (No DED)	20% (No DED)
In-Network Specialist	$30 SP	$30 SP	20% (No DED)	20% (No DED)
Out-of-Network	Not Covered	40% (No DED)	40% (No DED)	40% (No DED)
Colonoscopies (Routine)		Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	See Location of Service	$0	$0	$0
Out-of-Network	Not Covered	$0	$0	$0
Mammograms (Routine and Dx)				
In-Network	$0	$0	$0	$0
Out-of-Network	Not Covered	$0	$0	$0
Well Child Office Visits (No BPM)				
In-Network Family Physician	$15 PCP	$15 FP	20% (No DED)	20% (No DED)
In-Network Specialist	$30 SP	$30 SP	20% (No DED)	20% (No DED)
Out-of-Network	Not Covered	40% (No DED)	40% (No DED)	40% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE				
Ambulance Maximum (per Day)	No Maximum	$5,000	$5,000	$5,000
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Convenient Care Centers (CCC)				

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In-Network	$15 PCP	$20 FP	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)				
In-Network	$100	$100	DED + 20%	DED + 20%
Out-of-Network	$100	$100	DED + 40%	DED + 40%
Urgent Care Centers (UCC)				
In-Network	$30 SP	$30	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
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	DED + 20%	$100	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Independent Clinical Lab				
In-Network	$0	$0	DED	DED
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)				
In-Network - Advanced Imaging Services (AIS)	$0	$100	DED + 20%	DED + 20%
In-Network - Other Diagnostic Services	$0	$100	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Inpatient Hospital (per admit)				
In-Network	DED + 20%	Option 1 - $500 Option 2 - $1000	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%
Out-of-Network	Not Covered	$1,750	DED + 40%	DED + 40%
Inpatient Rehab Maximum	No Maximum	21 Days	21 Days	21 Days
Outpatient Hospital (per visit)				
In-Network	DED + 20%	Option 1 - $150 Option 2 - $250	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%
Out-of-Network	Not Covered	$350	DED + 40%	DED + 40%
Therapy at Outpatient Hospital				
In-Network	$15	Option 1 - $45 Option 2 - $60	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Hospitalization				
In-Network	$0	Option 1 - $0 Option 2 - $0	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%
Out-of-Network	Not Covered	40% (No DED)	DED + 40%	DED + 40%
Outpatient Hospitalization (per visit)				
In-Network	$0	Option 1 - $0 Option 2 - $0	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%
Out-of-Network	Not Covered	40% (No DED)	DED + 40%	DED + 40%
Provider Services at Hospital and ER				
In-Network Family Physician or Specialist	$0	$0	DED + 20%	DED + 20%
Out-of-Network Provider	Not Covered	$0	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Physician Office Visit				
In-Network Family Physician or Specialist	$0	$0	DED + 20%	DED + 20%
Out-of-Network Provider	Not Covered	40% (No DED)	DED + 40%	DED + 40%
Emergency Room Facility Services (per visit)				
In-Network	$0	$0	DED + 20%	DED + 20%
Out-of-Network	$0	$0	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Provider Services at Locations other than Hospital and ER				
In-Network Family Physician	$0	$0	DED + 20%	DED + 20%
In-Network Specialist	$0	$0	DED + 20%	DED + 20%
Out-of-Network Provider	Not Covered	40% (No DED)	DED + 40%	DED + 40%

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OTHER SPECIAL SERVICES AND LOCATIONS				
Advanced Imaging Services in Physician's Office				
In-Network Family Physician	$0	$150	DED + 20%	DED + 20%
In-Network Specialist	$0	$150	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Birthing Center				
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Diabetic Equipment and Supplies*				
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum
In-Network	Motorized Wheelchair: *$500 + DED + 20% All Other: DED + 20%*	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Home Health Care BPM	No Maximum	20 Visits	20 Visits	20 Visits
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Hospice LTM	No Maximum	No Maximum	No Maximum	No Maximum
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM	No Maximum. Auth Req for Therapy	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	30 days	60 Days	60 Days	60 Days
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
PRESCRIPTION DRUGS				
Deductible				
In-Network				
Retail (30 Days)	$15/$30/$50	$15/$30/$50	CYD + $15/$30/$50	CYD + $15/$30/$50
Generic/Preferred Brand/Non-Preferred				
Mail Order (90 Days)				
Generic/Preferred Brand/Non-Preferred	$40/$75/$125	$40/$75/$125	CYD + $40/$75/$125	CYD + $40/$75/$125
Out-of-Network				
Retail (30 Days)				
Generic/Preferred Brand/Non-Preferred	Not Covered	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Mail Order (90 Days)				
Generic/Preferred Brand/Non-Preferred	Not Covered	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Medical Pharmacy (Provider-Administered Rx)**		$200 Monthly OOP Max	$200 Monthly OOP Max applies after DED	$200 Monthly OOP Max applies after DED
In-Network	See Location of Service	20% (No DED)	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 50%	DED + 50%	DED + 50%

* 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.

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

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.