

Nassau County BOCC

Effective 10-1-15

PLAN DETAILS

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare 46	BlueOptions 03769	BlueOptions HSA-Compatible 05192 (Single Coverage)	BlueOptions HSA-Compatible 05193 (Family Coverage)	BlueCare 60
Deductible (DED) (Per Person/Family Agg)					
In-Network	\$2,000 / \$6,000	\$500 / \$1,500	\$2,500 / Not Applicable	\$5,000 / \$5,000	\$500 / \$1,000
Out-of-Network	Not Applicable	\$1,500 / \$4,500	\$5,000 / Not Applicable	\$10,000 / \$10,000	Not Applicable
Coinsurance (Member Responsibility)					
In-Network	10%	20%	20%	20%	10%
Out-of-Network	Not Applicable	50%	40%	40%	Not Applicable
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins and all Copays	Includes DED, Coins and all Copays	Includes DED, Coins and all Copays	Includes DED, Coins and all Copays	Includes DED, Coins and all Copays
In-Network	\$5,000 / \$10,000	\$3,000 / \$6,000	\$5,800 / Not Applicable	\$11,600 / \$11,600	\$3,500 / \$7,000
Out-of-Network	Not Applicable	\$6,000 / \$12,000	\$11,600 / Not Applicable	\$23,200 / \$23,200	Not Applicable
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES					
Allergy Injections					
In-Network Family Physician	\$10	\$10	DED + 20%	DED + 20%	\$10
In-Network Specialist	\$10	\$10	DED + 20%	DED + 20%	\$10
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
E-Office Visit Services					
In-Network Family Physician	\$10	\$10	DED + 20%	DED + 20%	\$25
In-Network Specialist	\$10	\$10	DED + 20%	DED + 20%	\$45
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Office Services					
In-Network Family Physician	\$35	\$25	DED + 20%	DED + 20%	\$25
In-Network Specialist	\$65	\$60	DED + 20%	DED + 20%	\$45
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Provider Services at Hospital and ER					
In-Network Family Physician	DED + 10%	\$100	DED + 20%	DED + 20%	\$0
In-Network Specialist	DED + 10%	\$100	DED + 20%	DED + 20%	\$0
Out-of-Network	Hospital: Not Covered ER: In-Ntwk DED + 10%	\$100	In-Ntwk DED + 20%	In-Ntwk DED + 20%	Hospital: Not Covered ER: \$0
Provider Services at Other Locations					
In-Network Family Physician	\$35	\$25	DED + 20%	DED + 20%	\$0
In-Network Specialist	\$65	\$60	DED + 20%	DED + 20%	\$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center or Hospital					
In-Network Specialist	ASC: \$65 Hospital: DED + 10%	ASC: \$60 Hospital: \$100	ASC: DED + 20% Hospital: DED + 20%	ASC: DED + 20% Hospital: DED + 20%	ASC: \$0 Hospital: \$0
Out-of-Network	Not Covered	ASC: \$60 Hospital: \$100	In-Ntwk DED + 20%	In-Ntwk DED + 20%	Not Covered

PREVENTIVE CARE					
Adult Wellness Office Services					
In-Network Family Physician	\$0	\$0	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0	\$0	\$0
Out-of-Network	Not Covered	50% (No DED)	40% (No DED)	40% (No DED)	Not Covered
Colonoscopies (Routine)					
	Age 50+ then Frequency Schedule Applies				
In-Network	\$0	\$0	\$0	\$0	\$0
Out-of-Network	Not Covered	\$0	\$0	\$0	Not Covered
Mammograms (Routine and Dx)					
In-Network	\$0	\$0	\$0	\$0	\$0
Out-of-Network	Not Covered	\$0	\$0	\$0	Not Covered
Well Child Office Visits (No BPM)					
In-Network Family Physician	\$0	\$0	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0	\$0	\$0
Out-of-Network	Not Covered	50% (No DED)	40% (No DED)	40% (No DED)	Not Covered
EMERGENCY/URGENT/CONVENIENT CARE					
Ambulance Maximum (ground / air and water - per day)					
In-Network	DED + 10%	DED + 20%	DED + 20%	DED + 20%	DED + 10%
Out-of-Network (Emergency Services Only)	In-Ntwk DED + 10%	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%	DED + 10%
Convenient Care Centers (CCC)					
In-Network	\$35	\$25	DED + 20%	DED + 20%	\$25
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Emergency Room Facility Services (also see Professional Provider Services)					
In-Network	\$300	\$300	DED + 20%	DED + 20%	\$100
Out-of-Network	\$300	\$300	DED + 20%	DED + 20%	\$100
Urgent Care Centers (UCC)					
In-Network	\$70	\$65	DED + 20%	DED + 20%	\$45
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
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	\$250	DED + 20%	DED + 20%	DED + 20%	DED + 10%
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Independent Clinical Lab					
In-Network	\$0	\$0	DED	DED	\$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)					
In-Network - Advanced Imaging Services (AIS)	\$300	DED + 20%	DED + 20%	DED + 20%	\$50
In-Network - Other Diagnostic Services	\$50	\$50	DED + 20%	DED + 20%	\$20
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered

Inpatient Hospital (per admit) In-Network	DED + 10%	Option 1 - DED + 20%	Option 1 - DED + 20%	Option 1 - DED + 20%	\$325 per Day up to \$1,625
Out-of-Network	Not Covered	Option 2 - DED + 20%	Option 2 - DED + 25%	Option 2 - DED + 25%	Not Covered
Inpatient Rehab Maximum	30 Days	DED + 50%	\$500 PAD + DED + 40%	\$500 PAD + DED + 40%	No Maximum
Outpatient Hospital (per visit) In-Network	Surgical: \$500	Option 1 - DED + 20%	Option 1 - DED + 20%	Option 1 - DED + 20%	Surgical: \$325
Out-of-Network	Non-Surgical: \$500	Option 2 - DED + 20%	Option 2 - DED + 25%	Option 2 - DED + 25%	Non-Surgical: \$0
Not Covered	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Therapy at Outpatient Hospital In-Network	\$65	Option 1 - \$45	Option 1 - DED + 20%	Option 1 - DED + 20%	\$25
Out-of-Network	Not Covered	Option 2 - \$60	Option 2 - DED + 25%	Option 2 - DED + 25%	Not Covered
		DED + 50%	DED + 40%	DED + 40%	
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient Hospitalization In-Network	\$0	Option 1 - \$0	Option 1 - DED + 20%	Option 1 - DED + 20%	\$0
Out-of-Network	Not Covered	Option 2 - \$0	Option 2 - DED + 20%	Option 2 - DED + 20%	Not Covered
		50% (No DED)	\$500 PAD + DED + 40%	\$500 PAD + DED + 40%	
Outpatient Hospitalization (per visit) In-Network	\$0	Option 1 - \$0	Option 1 - DED + 20%	Option 1 - DED + 20%	\$0
Out-of-Network	Not Covered	Option 2 - \$0	Option 2 - DED + 20%	Option 2 - DED + 20%	Not Covered
		50% (No DED)	DED + 40%	DED + 40%	
Provider Services at Hospital and ER In-Network Family Physician or Specialist	\$0	\$0	DED + 20%	DED + 20%	\$0
Out-of-Network Provider	Hospital: Not Covered	\$0	In-Ntwk DED + 20%	In-Ntwk DED + 20%	Hospital: Not Covered
	ER: \$0				ER: \$0
Physician Office Visit In-Network Family Physician or Specialist	\$0	\$0	DED + 20%	DED + 20%	\$0
Out-of-Network Provider	Not Covered	50% (No DED)	DED + 40%	DED + 40%	Not Covered
Emergency Room Facility Services (per visit) In-Network	\$0	\$0	DED + 20%	DED + 20%	\$0
Out-of-Network	\$0	\$0	In-Ntwk DED + 20%	In-Ntwk DED + 20%	\$0
Provider Services at Locations other than Hospital and ER In-Network Family Physician	\$0	\$0	DED + 20%	DED + 20%	\$0
In-Network Specialist	\$0	\$0	DED + 20%	DED + 20%	\$0
Out-of-Network Provider	Not Covered	50% (No DED)	DED + 40%	DED + 40%	Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS					
Advanced Imaging Services in Physician's Office In-Network Family Physician	\$300	DED + 20%	DED + 20%	DED + 20%	\$50
In-Network Specialist	\$300	DED + 20%	DED + 20%	DED + 20%	\$50
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Birth Center In-Network	DED + 10%	DED + 20%	DED + 20%	DED + 20%	\$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered

Durable Medical Equipment, Prosthetics, Orthotics BPM In-Network	No Maximum Motorized Wheelchair: \$500 All Other: \$0	No Maximum DED + 20%	No Maximum DED + 20%	No Maximum DED + 20%	No Maximum Motorized Wheelchair: \$500 All Other: \$25 Not Covered
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Home Health Care BPM In-Network	20 Visits \$0	20 Visits DED + 20%	20 Visits DED + 20%	20 Visits DED + 20%	No Maximum \$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Hospice LTM In-Network	No Maximum DED + 10%	No Maximum DED + 20%	No Maximum DED + 20%	No Maximum DED + 20%	No Maximum \$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
Outpatient Therapy and Spinal Manipulations BPM	35 Visits/26 Manipulations	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	No Maximum. Auth Req for Therapy
Skilled Nursing Facility BPM In-Network	60 Days DED + 10%	60 days DED + 20%	60 Days DED + 20%	60 Days DED + 20%	30 Days \$0
Out-of-Network	Not Covered	DED + 50%	DED + 40%	DED + 40%	Not Covered
PRESCRIPTION DRUGS					
Deductible In-Network	No DED	\$100 Brand CYD	INN DED	INN DED	No DED
Retail (30 days) Generic/Preferred Brand/Non-Preferred	\$10/\$50/\$80	\$10/\$50/\$80	\$10/\$50/\$80	\$10/\$50/\$80	\$10/\$60/\$100
Mail Order (90 days) Generic/Preferred Brand/Non-Preferred	\$25/\$125/\$200	\$25/\$125/\$200	\$25/\$125/\$200	\$25/\$125/\$200	\$25/\$150/\$250
Out-of-Network Retail (30 days) Generic/Preferred Brand/Non-Preferred	Not Covered	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	Not Covered
Mail Order (90 days) Generic/Preferred Brand/Non-Preferred	Not Covered	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	Not Covered
Medical Pharmacy Monthly In-Network OOP Max (Provider-Administered Rx)* In-Network	\$200	\$200	\$200 Applies after DED	\$200 Applies after DED	See Location of Service Not Covered
Out-of-Network	20% (No DED) Not Covered	20% (No DED) DED + 50%	DED + 20% DED + 50%	DED + 20% DED + 50%	

* (1) Medical Pharmacy Monthly OOP Max applies in-network only and is combined Preferred and Non-Preferred unless otherwise noted. It 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.

** See Proposal Assumptions for more details.

Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

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.