Summary of Benefits

City of Palm Coast – effective 1/1/15

COST SHARING Maximums shown are Per Calendar Year (PCY) unless noted otherwise	Blended Plan BlueOptions 03769	HDHP with H.S.A BlueOptions 03160 (Emp Only) or 03161 (Family)
Deductible (DED) (Per Person/Family Agg)	Emp Only / Family	Emp Only / Family
In-Network	$500 / $1,000	$1,500 / $3,000
Out-of-Network	$2,000 / $4,000	$3,000 / $6,000
Coinsurance (Member Responsibility)		
In-Network	20%	20%
Out-of-Network	40%	40%
Out of Pocket Maximum (Per Person/Family Agg)	;	Emp Only / Family
In-Network	$2,500 / $5,000	$2,500 / $5,000
Out-of-Network	$5,000 / $10,000	$5,000 / $10,000
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections		
In-Network Family Physician	$35	DED + 20%
In-Network Specialist	$50	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Office Services		
In-Network Family Physician	$35 FP	DED + 20%
In-Network Specialist	$50 SP	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Provider Services at Hospital		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Provider Services at Other Locations		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center; Emergency Room Physicians		
In-Network	DED + 20%	DED + 20%
Out-of-Network	In-Network DED + 20%	In-network DED + 20%
PREVENTIVE CARE		
Adult Wellness Office Services	No Maximum	No Maximum
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	$0	$0
Colonoscopies (Routine and Dx) 1st per calendar year		
In-Network	$0	$0
Out-of-Network	$0	$0
Mammograms (Routine and Dx) In and Out of Network	$0	$0
Well Child Office Visits		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	$0	$0
Vision (Including Refraction) PCY	1 Routine Exam	1 Routine Exam
In-Network	$0	$0
Out-of-Network	$0	$0
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance Maximum (per day)	No Maximum	No Maximum
In-Network	DED + 20%	DED + 20%
Out-of-Network	In-network DED + 20%	In-network DED + 20%
Convenient Care Centers		
In-Network	$35	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	$250	DED + 20%
Out-of-Network	$250	In-network DED + 20%
Urgent Care Centers		
In-Network	$75	DED + 20%
Out-of-Network	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.		

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Ambulatory Surgical Center		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Independent Clinical Lab		
In-Network	$0	DED
Out-of-Network	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS)	$200	DED + 20%
In-Network – Other Diagnostic Services	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Inpatient Hospital (per admit) – Inpatient Rehab Max (21 days)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Hospital (per visit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Therapy at Outpatient Hospital (See Outpatient Therapy Maximum)		
In-Network	$50	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Hospitalization (per visit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 20%	DED + 40%
Provider Services at Hospital and ER		
In-Network Physician	$0	DED + 20%
Out of Network	$0	In-network DED + 20%
Physician Office Visit		
In-Network Family Physician	$0	DED + 20%
In-Network Specialist	$0	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
ER Facility Services		
In-Network	$250	DED + 20%
Out-of-Network	$250	In-network DED + 20%
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Physician	$200	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics Maximum PCY		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Home Health Care Maximum PCY	60 Visits	60 Visits
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Hospice	No Maximum	No Maximum
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Therapy (Physical, occupational speech) PCY Maximum	30 Visits	30 Visits
Spinal Manipulations Maximum PCY	20 Visits	20 Visits
Skilled Nursing Facility BPM	60 days	60 Days
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
PRESCRIPTION DRUGS – 90 DAY RETAIL IS AVAILABLE (3X APPLICABLE COPAY)		
In Network - Retail (30 days)		(Copay/Coinsurance after DED)
Generic/Preferred Brand/Non-Preferred/Specialty Self-Injectables	$20 / $40 / $70 / 10%	$20 / $40 / $70 / 10%
In Network - Retail (90 days)		
Generic/Preferred Brand/Non-Preferred/Specialty Self-Injectables	$60 / $120 / $210 / 10%	$60 / $120 / $210 / 10%
Out-of-Network - Retail		
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%

- All specialty self injectables at the 4th tier and all other self injectables will be paid at the applicable copay.
- 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.