Marion County Employees – October 1, 2021 Health Plan Benefit Overview

PLAN DETAILS

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA Compatible 03160/ 03161 (Single / Family Coverage)	BlueCare HMO 45	BlueOptions Predictable Cost 05781	BlueOptions Predictable Cost 03359
MONTHLY RATES				
County Employee Only Premium	$551.06	$507.52	$608.28	$628.76
County Employee/Family Premium	$1,514.72	$1,591.26	$1,672.80	$1,802.66
Employee Single Monthly Contribution	$0	$30.50	$73.00	$107.00
Employee w/Family Monthly Contribution	$242.50	$255.00	$301.50	$469.00
Deductible (DED) (Per Person/Family Agg)				
In-Network	$1,350 / $2,700	$1,500 / $4,500	$1,500 / $4,500	$500 / $1,500
Out-of-Network	$2,500 / $5,000	N/A	$4,500 / $13,500	Combined with in-network
Coinsurance (Member Responsibility)				
In-Network	20%	10%	30%	20%
Out-of-Network	40%	N/A	50%	40%
Out of Pocket Maximum (Per Person/Family Agg)	DED, Coins, Copays, RX	DED, Coins, Copays, RX	DED, Coins, Copays, RX	DED, Coins, Copays, RX
In-Network	$5,000 / $5,000	$4,000 / $8,000	$5,500 / $11,000	$3,000 / $6,000
Out-of-Network	$10,000 / $10,000	N/A	$11,000 / $22,000	$5,000 / $10,000
PROFESSIONAL PROVIDER SERVICES				
Allergy Injections				
In-Network Family Physician	DED + 20%	$10	$10	$10
In-Network Specialist	DED + 20%	$10	$10	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Office Services				
Heart of Florida Employee Medical Center	DED	$0	$0	$0
In-Network Family Physician	DED + 20%	$30	$30	$25
In-Network Specialist	DED + 20%	$55	$55	DED + 20%
Medical Pharmacy Monthly In-Network OOP Max (Provider-Administered Rx)*	$200 applies after DED	$200 / $700	$200	$200
In-Network Preferred medication	DED + 20%	20% up to $200	20% (No DED)	20% (No DED)
In-Network Non-Preferred medication	Combined with Preferred OOP	20% up to $700	Combined with Preferred OOP	Combined with Preferred OOP
Out-of-Network	DED + 50%	Not Covered	DED + 50%	DED + 50%
Provider Services at Hospital and ER				
In-Network Family Physician	DED + 20%	DED + 10%	DED + 30%	DED + 20%
In-Network Specialist	DED + 20%	DED + 10%	DED + 30%	DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 30%	In-Ntwk DED + 20%
Provider Services at Other Locations				
In-Network Family Physician	DED + 20%	$30	$30	DED + 20%
In-Network Specialist	DED + 20%	$55	$55	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center or Hospital				
In-Network Specialist	ASC: DED + 20% Hospital: DED + 20%	ASC: $55 Hospital: DED + 10%	ASC: $55 Hospital: DED + 30%	ASC: DED + 20% Hospital: DED + 20%
Out-of-Network	In-Ntwk DED + 20%	Not Covered	ASC: $55 Hospital: In-Ntwk DED + 30%	In-Ntwk DED + 20%
PREVENTIVE CARE				

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Adult Wellness Office Services				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	$0	Not Covered	$0	$0
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	Not Covered	$0	$0
Mammograms (Routine and Dx)				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	Not Covered	$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	40% (No DED)	Not Covered	50% (No DED)	40% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE				
Ambulance Maximum (combined ground, air and water - per day)	Unlimited	Unlimited	Unlimited	Unlimited
In-Network	DED + 20%	DED + 10%	DED + 30%	DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 30%	In-Ntwk DED + 20%
Convenient Care Centers (CCC)				
In-Network	DED + 20%	$30	$30	$25
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)				
In-Network	DED + 20%	$250	DED + 30%	$100
Out-of-Network	DED + 20%	$250	DED + 30%	$100
Urgent Care Centers (UCC)				
In-Network	DED + 20%	$60	$60	$35
Out-of-Network	DED + 20%	Not Covered	DED + $60	DED + $35
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%	$200	$200	$100
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Independent Clinical Lab				
In-Network	DED	$0	$0	$0
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)				
In-Network - Advanced Imaging Services (AIS)	DED + 20%	$250	$250	$125
In-Network - Other Diagnostic Services	DED + 20%	$50	$50	$50
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Inpatient Hospital (per admit)				
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 30% Option 2 - DED + 30%	DED + 20% DED + 20%

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Out-of-Network	DED + 40%	Not Covered	$500 PAD + DED + 50%	DED + 40%
Inpatient Rehab Maximum	30 Days	30 Days	30 Days	30 Days
Outpatient Hospital (per visit)				
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - $400 Option 2 - $400	Option 1 - DED + 30% Option 2 - DED + 30%	DED + 20% DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Therapy at Outpatient Hospital				
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - $55 Option 2 - $55	Option 1 - $55 Option 2 - $70	Option 1 - $45 Option 2 - $60
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Hospitalization				
In-Network	Option 1 - DED + 20% Option 2 - DED + 20%	$0 $0	Option 1 - $0 Option 2 - $0	Option 1 - $0 Option 2 - $0
Out-of-Network	DED + 40%	Not Covered	50% (No DED)	40% (No DED)
Outpatient Hospitalization (per visit)				
In-Network	Option 1 - DED + 20% Option 2 - DED + 20%	$0 $0	Option 1 - $0 Option 2 - $0	Option 1 - $0 Option 2 - $0
Out-of-Network	DED + 40%	Not Covered	50% (No DED)	40% (No DED)
Provider Services at Hospital and ER				
In-Network Family Physician or Specialist	DED + 20%	$0	$0	$0
Out-of-Network Provider	In-Ntwk DED + 20%	Not Covered	$0	$0
Physician Office Visit				
In-Network Family Physician or Specialist	DED + 20%	$0	$0	$0
Out-of-Network Provider	DED + 40%	Not Covered	50% (No DED)	40% (No DED)
Emergency Room Facility Services (per visit)				
In-Network	DED + 20%	$0	$0	$0
Out-of-Network	In-Ntwk DED + 20%	$0 emergencies only	$0	$0
Provider Services at Locations other than Hospital and ER				
In-Network Family Physician	DED + 20%	$0	$0	$0
In-Network Specialist	DED + 20%	$0	$0	$0
Out-of-Network Provider	DED + 40%	Not Covered	50% (No DED)	40% (No DED)
OTHER SPECIAL SERVICES AND LOCATIONS				
Advanced Imaging Services in Physician's Office				
In-Network Family Physician	DED + 20%	$250	$250	$125
In-Network Specialist	DED + 20%	$250	$250	$125
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Birthing Center				
In-Network	DED + 20%	DED + 10%	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum	No Maximum	No Maximum	No Maximum
In-Network motorized wheelchairs	DED + 20%	$500	DED + 30%	DED + 20%
In-Network all others	DED + 20%	$0	DED + 30%	DED + 20%

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Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Home Health Care BPM	20 Visits	20 Visits	20 Visits	30 Visits
In-Network	DED + 20%	$0	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Hospice LTM	No Maximum	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM (locations other than hospital and physician's office)	35 Visits (Includes up to 26 Spinal 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)
In-Network	DED + 20%	$55	$55	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
Skilled Nursing Facility BPM	60 Days	60 Days	60 Days	90 days
In-Network	DED + 20%	DED + 10%	DED + 30%	DED + 20%
Out-of-Network	DED + 40%	Not Covered	DED + 50%	DED + 40%
PRESCRIPTION DRUGS				
Deductible	Calendar year then	$100 Brand only	$100 Brand only	$100 Brand only
In-Network				
Heart of Florida Employee Medical Center				
Generic/Preferred Brand/Non-Preferred	$0 / $25 / $40	$0 / $30 / $40	$0 / $30 / $50	$0 / $30 / $50
Retail (30 days)				
Generic/Preferred Brand/Non-Preferred	$10 / $50 / $80	$10 / $60 / $80	$10 / $60 / $100	$10 / $60 /$100
Mail Order (90 days)				
Generic/Preferred Brand/Non-Preferred **Out-of-Network Pharmacy** **In-Network Specialty Pharmacy/Drugs** CareMark – 1-866-278-5108 AllianceRX – 877-627-6337 (specialty drugs – 30 day supply limit) **Out-of-Network** – any pharmacy other than Caremark or AllianceRX	$25 / $125 / $200 50% of allowance DED then applicable copayment 50% of RX allowance reimbursed after member submits claim	$25 / $150 / $200 Not Covered DED then applicable copayment Out of Network – Not Covered	$25 / $150 /$250 50% of allowance RX DED then applicable copayment 50% of RX allowance reimbursed after member submits claim	$25 / $150 / $250 50% of allowance RX DED then applicable copayment 50% of RX allowance reimbursed after member submits claim

Generic Substitution Program – When members choose to fill a brand-name prescription when a lower cost generic equivalent is available, the member pays the brand cost (deductible, copayment and/or coinsurance) and the cost difference between the brand and generic drug. NOTE: if brand medication is medically necessary, physician must write medically necessary on the prescription, the penalty is waived and member receives brand drug at brand cost.
Responsible RX Pharmacy Utilization Programs – Responsible Dose: medication dose and compliance initiative; Responsible Quantity: coverage maximums initiative; Responsible Steps: prerequisite medications utilized prior to higher cost brand drug coverage; Drug exclusion: non covered medications
Medication Guide and Updates – www.floridablue.com click members then scroll down click prescriptions, medication guides and specialty pharmacy then medication guide July 2014. On-line medication guides are updated each 6 months any changes prior to the updated guide will be found on the 2nd link medication guide update current quarter.

DED-deductible PAD- per admission deductible RX- prescription BPM-benefit period maximum LTM-life time maximum HSA-health savings account

* (1) Medical Pharmacy Monthly Out Of Pocket (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.

Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit . Diabetic Equipment (insulin pumps, tubing) are covered under the medical durable equipment 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 Florida Blue, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Florida Blue's Benefit Booklet and Schedule of Benefits; their terms prevail.

The information contained in this document 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.

Additionally, Interim rules released by the Federal Government February 2, 2010 require Florida Blue to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE).