

BlueCare

Santa Rosa Cnty Bd of Cnty Commissioners
Health Benefit Summary Plan 41

Florida Blue 
HMO

When you enroll in a BlueCare health plan, you will choose a Florida Blue HMO contracting Primary Care Physician to help coordinate your overall health care.

Benefits

Cost to You

Deductible (DED) Per Benefit Period

In-Network (Per Individual / Per Family)

\$500 / \$1,000

Coinsurance Percentage (Amount Member Pays)

In-Network Providers

20%

Physician Office Services

Primary Care Physician office services

\$15 copay per visit

Contracting Specialist office services

\$30 copay per visit

Visit to contracting GYN for well-woman exam

\$0 copay per visit

Adult Wellness & Well Child Office Visits

\$0 copay per visit

These office services may include:

- Pediatric and well-baby care
- Periodic health evaluation and immunizations
- Other diagnostic services
- Health education
- Professional counseling (family planning, nutritional, and medical social services)
- Vision and hearing screening
- Family planning services
- In-office surgery

Additional Services (Office or Outpatient Facility)

Allergy testing

No copay

Allergy injection, including serum

\$5 copay per visit

Outpatient physical, speech, cardiac and occupational therapies

\$15 copay per visit

Diagnostic lab and X-ray

No copay

Hospital Services (Inpatient Facility)

Room and board

DED + Coinsurance

These inpatient hospital services may include:

- Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications
- Intensive Care Unit and other special units
- Laboratory and X-ray services
- Inpatient physical, speech, cardiac and occupational therapies

Florida Blue HMO is a trade name of Health Options, Inc., an HMO subsidiary of Florida Blue. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.

BlueCare

Santa Rosa Cnty Bd of Cnty Commissioners Health Benefit Summary Plan 41

Benefits

Hospital or Ambulatory Surgical Center (Outpatient Facility)

Outpatient and outpatient surgical services may include:
Anesthesia, use of operating and recovery rooms,
oxygen, drugs and medications, including:

- Hospital or surgical center
- Surgeon's fees
- Outpatient laboratory, X-ray, and other tests

Emergency Services (Hospital)

Use of emergency rooms and emergency services
at contracting hospitals

Use of emergency rooms and emergency services
outside of service area or at non-contracting hospitals

Maternity Services

Primary Care Physician office services

Contracting Specialist office services – initial OB visit only

Certified Nurse Midwife or Midwife

Inpatient hospital services

Birthing center services

Behavioral Health Services

Mental Health Care/Substance Dependency

Inpatient Hospitalization Facility Services (per admit)

In-Network

Out-of-Network

Outpatient Hospitalization Facility Service (per visit)

In-Network

Out-of-Network

Emergency Room Facility Services (per visit)

In-Network and Out-of-Network

Provider Services at Hospital and ER

In-Network Family Physician/Specialist

Out-of-Network

Provider Services at Locations other than Hospital or ER

In-Network Family Physician/Specialist

Out-of-Network

Outpatient Office Visit

In-Network Family Physician/Specialist

Out-of-Network

Infertility Services

Primary Care Physician

Contracting Specialist

Cost to You

DED + Coinsurance

\$100 copay per visit

\$100 copay per visit

\$15 copay

\$30 copay

No copay

DED + Coinsurance

No copay

\$0

Not Covered

\$0

Not Covered

\$0

\$0

\$0

\$0

Not Covered

\$0

Not Covered

\$15 copay per visit

\$30 copay per visit

BlueCare

Santa Rosa Cnty Bd of Cnty Commissioners Health Benefit Summary Plan 41

Benefits

Special Services

Hospice care
Skilled nursing facility – 30 days per benefit period
Home health care – No benefit period maximum
Ambulance (medically necessary)
Durable medical equipment

- Motorized wheelchair
- All other durable medical equipment

Prosthetics and orthotics

Maximum Out-of-Pocket

(Includes DED, Coinsurance and Copayments, including Pharmacy.)

Cost to You

No copay
No copay
No copay
DED + Coinsurance
\$500 copay + DED + Coinsurance
DED + Coinsurance
No copay
\$3,500 per Member
\$7,000 per family

Select Exclusions and Limitations

The following is a partial listing of services that are excluded from coverage under the Master Policy. For a complete listing please refer to the Master Policy.

- All services not specifically listed in the Covered Services section of your Member Handbook or in any rider or endorsement, unless such services are specifically required by state or federal law
- Elective cosmetic surgery
- Hearing aids or eyeglasses, dental care, or oral appliances
- Physical for insurance, licensing, school or recreational purposes
- Elective abortions
- Workers' compensation
- Prescription drugs (unless included through BlueCare Rx)
- Complementary and Alternative Healing Methods (CAM)

The copayments are the responsibility of the Member and must be paid to the provider at the time service is rendered.

Prescription Drug Program

In the event your Group has selected a Pharmacy Program from Florida Blue HMO, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of the program features and how to take advantage of them.

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 Florida Blue HMO. These benefits apply only to groups of 51 or more employees. This does not constitute a contract. For a complete description of benefits and exclusions, please see Master Policy 86002; its terms prevail.