

Schedule of Benefits

The City of West Palm Beach (Police Plan)

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.

COST SHARING (AMOUNT MEMBER PAYS)	BlueOptions 05360
Deductible (DED) (Per Person/Family Aggregate)	
Individual (In and Out-of-Network)	\$200
Family (In and Out-of-Network)	\$600
Coinsurance (Member Responsibility)	
In-Network	10%
Out-of-Network	30%
Out of Pocket Maximum (Per Person/Family Aggregate)	Includes DED, Coins, & Copays; excludes Rx
Individual (In and Out-of-Network)	\$1,500
Family (In and Out-of-Network)	\$3,000
Lifetime Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES	
Allergy Injections	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 30%
E-Office Visit Services	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 30%
Office Services	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 30%
Provider Services at Hospital and Emergency Room	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 10%
Provider Services at Other Locations	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 30%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center	
In-Network Specialist	DED + 10%
Out-of-Network	DED + 10%
PREVENTIVE CARE	
Adult Wellness Office Services	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network	30% (No DED)
Colonoscopies	Age 50+ then Frequency Schedule Applies
In-Network	\$0 Copay
Out-of-Network	\$0 Copay
Independent Clinical Lab	
In-Network	\$0 Copay
Out-of-Network	30% (No DED)
Independent Diagnostic Testing Facility - X-Rays and AIS (Includes Physician Services)	
In-Network - Advanced Imaging Services (AIS)	\$0 Copay
In-Network - Other Diagnostic Services	\$0 Copay
Out-of-Network	30% (No DED)
Mammograms (Routine and Diagnostic)	
In-Network	\$0 Copay
Out-of-Network	\$0 Copay
Outpatient Hospital (per visit)	
In-Network	\$0 Copay
Out-of-Network	30% (No DED)
Provider Services at Outpatient Facility	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network	30% (No DED)
Well Child Office Visits	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network	30% (No DED)

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EMERGENCY/URGENT/CONVENIENT CARE	
Ambulance Maximum (per Day)	\$5,000
In-Network	DED + 10%
Out-of-Network	DED + 10%
Convenient Care Centers (CCC)	
In-Network	DED + 10%
Out-of-Network	DED + 30%
Emergency Room Facility Services	
In-Network	DED + 10%
Out-of-Network	DED + 10%
Urgent Care Centers (UCC)	
In-Network	DED + 10%
Out-of-Network	DED + 10%
FACILITY SERVICES - HOSP/SURG/ICL/IDTF	
Ambulatory Surgical Center	
In-Network	DED + 10%
Out-of-Network	DED + 30%
Independent Clinical Lab	
In-Network	\$0 Copay
Out-of-Network	DED + 30%
Independent Diagnostic Testing Facility - X-Rays and AIS (Includes Physician Services)	
In-Network - Advanced Imaging Services (AIS)	DED + 10%
In-Network - Other Diagnostic Services	DED + 10%
Out-of-Network	DED + 30%
Inpatient Hospital (per admit)	
In-Network	DED + 10%
Out-of-Network	DED + 30%
Inpatient Rehab Maximum	21 Days
Outpatient Hospital (per visit)	
In-Network	DED + 10%
Out-of-Network	DED + 30%
Therapy at Outpatient Hospital	
In-Network	DED + 10%
Out-of-Network	DED + 30%
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Hospitalization	
In-Network	\$0 Copay
Out-of-Network	30% (No DED)
Outpatient Hospitalization (per visit)	
In-Network	\$0 Copay
Out-of-Network	30% (No DED)
Provider Services at Hospital and Emergency Room	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network Provider	\$0 Copay
Physician Office Visit	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network Provider	30% (No DED)
Emergency Room Facility Services (per visit)	
In-Network	\$0 Copay
Out-of-Network	\$0 Copay
Provider Services at Other Locations	
In-Network Family Physician or Specialist	\$0 Copay
Out-of-Network Provider	30% (No DED)
OTHER SPECIAL SERVICES AND LOCATIONS	
Advanced Imaging Services in Physician's Office	
In-Network Family Physician or Specialist	DED + 10%
Out-of-Network	DED + 30%
Birth Center	
In-Network	DED + 10%
Out-of-Network	DED + 30%
Diabetic Equipment and Supplies*	
In-Network	DED + 10%
Out-of-Network	DED + 30%

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Durable Medical Equipment, Prosthetics, Orthotics BPM	Enteral Formulas: \$2,500 All Other: No Maximum
In-Network	DED + 10%
Out-of-Network	DED + 30%
Home Health Care BPM	60 visits
In-Network	DED + 10%
Out-of-Network	DED + 30%
Hospice LTM	No Maximum
In-Network	DED + 10%
Out-of-Network	DED + 30%
Outpatient Therapy and Spinal Manipulations BPM (includes physical, speech, occupational, massage, cardiac therapy)	100 visits for all therapies combined (includes up to 26 Spinal Manipulations)
In-Network	DED + 10%
Out-of-Network	DED + 30%
Skilled Nursing Facility BPM	60 Days
In-Network	DED + 10%
Out-of-Network	DED + 30%
PRESCRIPTION DRUGS	
Deductible	Not Applicable
In-Network	
Retail (30 Days)	
Generic/Preferred Brand/ Non-Preferred Brand	\$10 / \$25 / \$25
Mail Order (90 Days)	
Generic/Preferred Brand/ Non-Preferred Brand	\$20 / \$50 / \$50
Out-of-Network	
Retail (30 Days)	
Generic/Preferred Brand/ Non-Preferred Brand	50% / 50%
Mail Order (90 Days)	
Generic/Preferred Brand/ Non-Preferred Brand	50% / 50%
Medical Pharmacy (Provider-Administered Rx)**	\$200 Monthly OOP Max
In-Network	20% (No DED)
Out-of-Network	DED + 50%

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit. 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.

