AGENDA
SPECIAL COMMISSION MEETING

5:30 PM - Thursday, August 17, 2023
Commission Chambers

Page

1. CALL TO ORDER
2. PLEDGE OF ALLEGIANCE
3. ROLL CALL
4. PUBLIC COMMENTS RELATED TO AGENDA ITEMS / GOOD & WELFARE
5. PRESENTATIONS
   - 5.1. Employee Insurance Benefits - Pension Advisor Rosen — 2 - 29
     2023 Employee Healthcare Benefits
6. ANNOUNCEMENTS
   - 6.1. Back to School Giveaway, Saturday, August 19 from 10:00 AM to 4:00 PM at Town Hall
7. ADJOURNMENT

IN ACCORDANCE WITH THE PROVISIONS OF F.S. SECTION 286.0105, IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE BOARD, AGENCY, OR COMMISSION WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING OR HEARING, HE OR SHE WILL NEED A RECORD OF THE PROCEEDINGS, AND, FOR SUCH PURPOSE, HE OR SHE MAY NEED TO ENSURE THAT A VERBATIM RECORD OF THE PROCEEDINGS IS MADE, WHICH RECORD INCLUDES THE TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

ANY PERSON REQUIRING AUXILIARY AIDS AND SERVICES AT THIS MEETING MAY CALL THE TOWN CLERKS OFFICE AT 954-966-4600 AT LEAST TWO CALENDAR DAYS PRIOR TO THE MEETING. IF YOU ARE HEARING OR SPEECH IMPAIRED PLEASE CONTACT THE FLORIDA RELAY SERVICES BY USING THE FOLLOWING NUMBERS: 1-800-955-8770 (VOICE) OR 1-800-955-8771 (TDD)

DECORUM - ALL COMMENTS MUST BE ADDRESSED TO THE COMMISSION AS A BODY AND NOT TO INDIVIDUALS. ANY PERSON MAKING IMPERTINENT OR SLANDEROUS REMARKS, OR WHO BECOMES BOISTEROUS WHILE ADDRESSING THE COMMISSION, SHALL BE BARRED FROM FURTHER AUDIENCE BEFORE THE COMMISSION BY THE PRESIDING OFFICER, UNLESS PERMISSION TO CONTINUE OR AGAIN ADDRESS THE COMMISSION IS GRANTED BY THE MAJORITY VOTE OF THE COMMISSION MEMBERS PRESENT. NO CLAPPING, APPLAUDING, HECKLING OR VERBAL OUTBURSTS IN SUPPORT OR IN OPPOSITION TO A SPEAKER OR HIS/HER REMARKS SHALL BE PERMITTED. NO SIGNS OR PLACARDS SHALL BE ALLOWED IN THE COMMISSION CHAMBERS. PLEASE MUTE OR TURN OFF YOUR CELL PHONE OR PAGER AT THE START OF THE MEETING. FAILURE TO DO SO MAY RESULT IN BEING BARRED FROM THE MEETING. PERSONS EXITING THE CHAMBER SHALL DO SO QUIETLY.

Marlen D. Martell
Town Clerk

Additional Information

United Healthcare offers 172 plans, I have chosen plans that match your current benefits as well as the 3 best HMO's, POS/PPO's.

Aetna will not write towns, cities or municipalities with a fully insured plan. They only write self-funded plans.

Humana no longer offers group health insurance in the state of Florida.

Cigna will not write fully insured plans, only self-funded plans, they would also require a medical questionnaire.

Allstate is now offering group health; however, they need each employee to fill out a medical questionnaire on themselves and their dependents in order to get a quote. They do not offer fully insured plans. It would be a high deductible self-funded plan with a gap policy.

AvMed is not competitive in the small group market.

Advantages of a Self-Funded Health Plan

Self-funding a health plan incorporates several potential advantages for employers, including the following:

- There is more flexibility in customizing the plan to the employer's goals and the employee population.
- The employer has more control over selecting, monitoring and coordinating all plan vendors.
- The employer retains funds when health claims are lower than expected.
- Self-funding a health plan is often less costly because:
    - There are no profit or risk margins to pay to an insurer.
    - There are no state-levied premium taxes.
- The plan does not need to satisfy certain ACA mandates and is not subject to state insurance laws and mandates.
- It is easier to access data on health care usage to identify trends and opportunities for cost savings.

Disadvantages of a Self-Funded Health Plan

Self-funding a health plan also carries a number of disadvantages, including the following:

- The employer is exposed to risk of high losses due to extraordinary claims.
- Current year expenses will be unpredictable.
- There is a possibility of financial loss due to operational inefficiencies.
- The risk of regulatory penalties and lawsuits increases due to the potential for errors caused by ignorance or lack of understanding.
- There is a higher risk of in-house fraud or abuse.
- The employer is exposed to higher risk based on demographics of the employee population (e.g., an employee population that skews older could increase the risk of high health claims).

Town of Pembroke Park
BCBS Current Plans with GAP

Status	Current BlueCare Plan 14256	Current Transamerica GAP Plan	Total	Renewal BlueCare Plan 14256	Renewal Transamerica GAP Plan	Total
Employee	$770.27	$65.26	$835.53	$748.05	$73.24	$821.29
EE & Spouse	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
EE & Child(ren)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Family	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

This plan is for single employees only.

Status	Current BlueCare Plan 18410	Current Transamerica GAP Plan	Total	Renewal BlueCare Plan 18410	Renewal Transamerica GAP Plan	Total
Employee	$557.72	$98.48	$656.20	$554.43	$98.48	$652.91
EE & Spouse	$1,115.44	$207.83	$1,323.27	$1,108.85	$207.83	$1,316.68
EE & Child(ren)	$1,031.79	$176.18	$1,207.97	$1,025.69	$176.18	$1,201.87
Family	$1,589.51	$308.37	$1,897.88	$1,580.11	$308.37	$1,888.48

This plan is for employees with dependents.

Under this plan, each employee receives a Health Reinbursment Account (HRA) for $800 to help offset doctor visit co-payments.

BlueCare

For Small Groups
All Copay Health Plan 14256

Florida Blue HMO
Your local Blue Cross Blue Shield

1A

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Financial Features		
Deductible (DED)[1] (PBP)[2] (DED is the amount the member is responsible for before Florida Blue HMO pays)	$1,000 per person $3,000 per family	NA per person NA per family
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	NA
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$4,900 per person $9,800 per family	NA per person NA per family
Office Services		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$45 Copay	Not Covered
Physician Office Services		
Value Choice Primary Care Physician[4]	$0 Copay	Not Covered
Value Choice Specialist[4]	$20 Copay	Not Covered
Primary Care Physician	$20 Copay	Not Covered
Specialist	$45 Copay	Not Covered
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$20 Copay	Not Covered
Specialist	$45 Copay	Not Covered
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	Not Covered
Specialist	$10 Copay	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$45 Copay	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) **Monthly Out-of-Pocket Maximum**[5]		
Low:	$100	NA
Standard:	$200	NA
Health Care Professional Administered Medications		
Low:	10%	Not Covered
Standard:	20%	Not Covered
Important Note: Physician-Administered Medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical benefit*. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		

[1]DED = Deductible / [2]PBP = Per Benefit Period / [3]Virtual Visit services are only covered for In-Network providers in Florida. / [4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / [5]In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

76828-0722R E (Gold)

BlueCare
For Small Groups
All Copay Health Plan 14256

Florida Blue
HMO
Your local Blue Cross Blue Shield

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0 Copay	Not Covered
Mammograms	$0 Copay	Not Covered
Colonoscopy (Routine for age 45+)	$0 Copay	Not Covered
Emergency Medical Care		
Urgent Care Centers		
Value Choice Provider[4]	$0 Copay - Visits 1-2 PBP $50 Copay for Remaining Visits PBP	Not Covered
All Other Providers	$50 Copay	Not Covered
Emergency Room Facility Services (per visit) (cost share waived if admitted)	$350 Copay	$350 Copay
Ambulance Services	DED + 20%	INN DED + 20%
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$100 Copay	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$250 Copay	Not Covered
Independent Clinical Lab (e.g., Blood Work)	$25 Copay	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	$350 Copay	Not Covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$200 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)		
Therapy Services	$55 Copay	Not Covered
All other Services	$350 Copay	Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	$500 per day ($2500 Max)	Not Covered

[4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available.

76828-0722R E (Gold)

Mental Health / Substance Dependency		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Physician Office Services		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Emergency Room Facility Services (per visit) (cost share waived if admitted)	$0 Copay	$0 Copay
Outpatient Hospitalization Facility Service (per visit)	$0 Copay	Not Covered
Inpatient Hospitalization Facility Services (per admit)	$0 Copay	Not Covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$45 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)	$55 Copay	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics		
Motorized Wheelchair	DED + 20%	Not Covered
All Other	$0 Copay	Not Covered
Home Health Care	$0 Copay	Not Covered
Skilled Nursing Facility	DED + 20%	Not Covered
Hospice	DED + 20%	Not Covered

[3]Virtual Visit services are only covered for In-Network providers in Florida.

Summary of Benefits for Covered Services — Amount Member Pays

Prescription Drug Program (BlueCare Rx®)	**Preferred In-Network Retail Pharmacy** (1-month supply)	**Standard In-Network Retail Pharmacy** (1-month supply)	**In-Network Home Delivery** (3-month supply)	**Out-of-Network**
Pharmacy Deductible (PDED)	NA			Not Applicable
Generic Drugs:				
1. Preventive[6] (e.g., oral contraceptives)	$0	$10	$0	Not Covered
2. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$4	$14	$8	Not Covered
3. All Other Generics	$15	$25	$30	Not Covered
Brand Drugs:				
4. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$30	$50	$60	Not Covered
5. All Other Preferred Brand Drugs	$60	$70	$120	Not Covered
Non-Preferred Drugs:				
6. Non-Preferred Brand Drugs	$100	$120	$200	Not Covered
Specialty				
7. Specialty Drugs purchased from a Specialty Pharmacy	$200	$200	Not Covered	Not Covered
Oral Chemotherapy Drugs	$10	$10	$20	Not Covered

*Specialty Drugs are not available through Mail Order				

Important Notes

- Preferred Pharmacy Network includes Walgreens, Walmart, Publix, Winn-Dixie, and FHCP. To find a participating Preferred Pharmacy, please see our Online Provider Directory. Participating pharmacies will be identified with an orange "Preferred Pharmacy" designation.
- Home Delivery and Specialty Drugs are excluded from the Preferred Pharmacy Network.
- Inform the member that if a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the member will be responsible for: 1) the Copayment applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueCare Rx Pharmacy Program Schedule of Benefits.
- BlueCare Rx Pharmacy benefit also provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost. Additionally, certain vaccines which are covered under the Wellness Benefits can be administered by Pharmacists who are certified.

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Pediatric Dental (under age 19)[7]		
Preventive, Basic and Major	$0	Not Covered
Pediatric Vision (under age 19)[7]		
Exam	$0	Not Covered
Eyeglass Lenses	$0	Not Covered
Frames	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 20% discount (No discount at Sam's/Walmart)	Not Covered
Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 15% discount (No discount at Sam's/Walmart)	Not Covered
Important Note: Anything over the allowance will not go toward your out-of-pocket maximum.		

[6]Preventive Medication and Condition Care Rx Lists are available in the Medication Guide. / [7]Pediatric Dental and Vision Benefits end on the last day of the month of the member's 19th birthday.

Benefit Maximums	
Home Health Care	60 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Inpatient Habilitation Therapy	30 Days PBP
Outpatient Rehabilitation Therapy	35 Visits PBP
Outpatient Habilitation Therapy	35 Visits PBP
Spinal Manipulations	35 PBP(accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Preauthorization for select services: Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Additional Benefits and Features

- Encourage our members to call the care consultants team at 1-888-476-2227 to find out more about their benefits and/or treatment options. This can help them save time and money.
- Let our members know that there is online access to about everything on their health benefit plan as well as all of our self-service tools.
- Let our members know they can go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in the plan's network and they don't need a referral to see a participating provider.

This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue HMO. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueCare
For Small Groups
Essential Health Plan 18410

Florida Blue HMO
Your local Blue Cross Blue Shield

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Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Financial Features		
Deductible (DED)[1] (PBP)[2] (DED is the amount the member is responsible for before Florida Blue HMO pays)	$7,500 per person $15,000 per family	NA per person NA per family
Coinsurance (Coinsurance is the percentage the member pays for services)	50% of the allowed amount	NA
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$8,700 per person $17,400 per family	NA per person NA per family
Office Services		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$95 Copay	Not Covered
Physician Office Services		
Value Choice Primary Care Physician[4]	$0 Copay	Not Covered
Value Choice Specialist[4]	$20 Copay	Not Covered
Primary Care Physician	$65 Copay	Not Covered
Specialist	$95 Copay	Not Covered
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$65 Copay	Not Covered
Specialist	$95 Copay	Not Covered
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	Not Covered
Specialist	$10 Copay	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$95 Copay	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) **Monthly Out-of-Pocket Maximum**[5]		
Low:	$100	NA
Standard:	$200	NA
Health Care Professional Administered Medications		
Low:	10%	Not Covered
Standard:	20%	Not Covered
Important Note: Physician-Administered Medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical benefit*. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		

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89381-0722R (Bronze)

BlueCare
For Small Groups
Essential Health Plan 18410

Florida Blue
HMO
Your local Blue Cross Blue Shield

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0 Copay	Not Covered
Mammograms	$0 Copay	Not Covered
Colonoscopy (Routine for age 45+)	$0 Copay	Not Covered
Emergency Medical Care		
Urgent Care Centers		
Value Choice Provider[4]	$0 Copay - Visits 1-2 PBP $100 Copay for Remaining Visits PBP	Not Covered
All Other Providers	$100 Copay	Not Covered
Emergency Room Facility Services (per visit) (cost share waived if admitted)	DED + 50%	INN DED + 50%
Ambulance Services	DED + 50%	INN DED + 50%
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	DED + 50%	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 50%	Not Covered
Independent Clinical Lab (e.g., Blood Work)	$50 Copay	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	DED + 50%	Not Covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	50%	Not Covered
Outpatient Hospital Facility Services (per visit)		
Therapy Services	DED + 50%	Not Covered
All other Services	DED + 50%	Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	DED + 50%	Not Covered

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Mental Health / Substance Dependency		
Virtual Visits[3]		
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Specialist	$0 Copay	Not Covered
Physician Office Services		
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Inpatient Hospitalization Facility Services (per admit)	$0 Copay	Not Covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$95 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)	DED + 50%	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics		
Motorized Wheelchair	DED + 50%	Not Covered
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Home Health Care	DED + 50%	Not Covered
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Pharmacy Deductible (PDED)	IN-Network Health DED (Tier 7)			Not Applicable
Generic Drugs:				
1. Preventive[6] (e.g., oral contraceptives)	$0	$10	$0	Not Covered
2. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$4	$14	$8	Not Covered
3. All Other Generics	$40	$50	$80	Not Covered
Brand Drugs:				
4. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$75	$95	$150	Not Covered
5. All Other Preferred Brand Drugs	$150	$160	$300	Not Covered
Non-Preferred Drugs:				
6. Non-Preferred Brand Drugs	$250	$270	$500	Not Covered
Specialty				
7. Specialty Drugs purchased from a Specialty Pharmacy	PDED	PDED	Not Covered	Not Covered
Oral Chemotherapy Drugs	$10	$10	$20	Not Covered

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Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 15% discount (No discount at Sam's/Walmart)	Not Covered
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Additional Benefits and Features

- Encourage our members to call the care consultants team at 1-888-476-2227 to find out more about their benefits and/or treatment options. This can help them save time and money.
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HELPING WITH YOUR MEDICAL COSTS

TRANSCONNECT® WITH OUTPATIENT LAB RIDER FOR FLORIDA SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

TransConnect for Florida, underwritten by Transamerica Life Insurance Company

Andrea was involved in a serious car accident. After the whirlwind of the ambulance ride, ER, surgery, and hospital stay, she's nervous about how much her major medical insurance will pay. It's a relief to remember that she signed up for *TransConnect* which can pay for out-of-pocket expenses like deductibles, co-insurance, and co-payments.

MONTHLY PREMIUM
You
You and your spouse
You and your child(ren)
You, your spouse and your child(ren)

Visit:
transamerica.com

Customer Service:
888-763-7474

INPATIENT HOSPITAL BENEFITS

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determines your calendar year maximum benefit (multiplied by three for an insured family).

OUTPATIENT HOSPITAL BENEFITS WITH OUTPATIENT LAB RIDER

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) tests performed in a physician's office (X-rays are not included)
- Cardiac catheterizations and stress tests
- Accident, injury, or emergency condition treatment in a hospital ER or urgent care center
- Laboratory tests performed on an outpatient basis in an independent laboratory (a lab that is independent of both an attending or consulting physician's office and of a hospital).

ACCIDENT-ONLY AMBULANCE BENEFIT

This benefit is payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident. Ambulance transportation must be within 72 hours of the accident and must be provided by a licensed professional ambulance company.

ELIGIBILITY

You must be actively employed qualifying as an eligible insured (defined by the employer) and have an employer's basic, major medical, or comprehensive medical plan.

TRANSAMERICA®

1A + B GAP Plan

IMPORTANT PLAN PROVISIONS

Your employer selects benefit amounts, paid only for deductibles, co-insurance, and co-pays incurred when your major medical plan pays for specified treatments and care.

HOW TO SUBMIT A CLAIM

The ID card you'll receive after enrollment should be presented at time of service so providers are paid directly after your major medical carrier determines what you owe. If you don't do so at time of service, simply submit a *TransConnect* ® claim form, UB92 or HCFA (the itemized service provider's bill), and the Explanation of Benefits (EOB) from the major medical carrier showing what you owe after what they paid.

EXCLUSIONS

No benefits are payable under this policy/certificate for any expenses incurred:

- Late enrollees subject to a 30-day waiting period
- During any period the insured person does not have coverage under another medical plan
- As the result of suicide or any attempted suicide, while sane or insane
- For any intentionally self-inflicted injury or sickness
- For rest care or rehabilitative care and treatment
- For voluntary abortion except, with respect to the insured or insured spouse where the insured or the insured's dependent spouse's life would be endangered if the fetus were carried to term; or where medical complications have arisen from abortion
- As a result of commission of a felony
- As a result of participation in a riot, civil commotion, civil disobedience, or unlawful assembly. Excludes loss occurring while acting in a lawful manner within the scope of authority.
- As a result of participation in a contest of speed in power-driven vehicles, parachuting, or hang gliding
- As a result of air travel, except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member
- As a result of intoxication as determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred
- For alcoholism or drug use, unless such drugs were taken on the advice of a physician and taken as prescribed while hospital confined as an inpatient
- For any loss incurred while on active duty status in the armed forces of any country. If you notify us of such active duty, we will refund any premium paid for any period for which no benefits are provided as a result of this exclusion.
- For pregnancy of a dependent child
- For sex changes
- For experimental treatment, procedures, devices, drugs, or surgery (except that bone marrow transplants will not be considered experimental in the treatment of cancer)
- For accident or sickness arising out of and in the course of any occupation for compensation, wage, or profit (does not apply to sole proprietors or partners not covered by workers' compensation)
- For mental illness or functional or organic nervous disorders — regardless of the cause — if the other medical plan does not cover these conditions
- For dental or vision services, including, but not limited to, treatment, surgery, extractions, or X-rays, unless resulting from an accident occurring while the insured person's insurance under this policy is in force and if performed within 12 months of the date of such accident; or due to congenital disease or anomaly of an insured newborn child; and to assure the safe delivery of necessary dental care provided to an insured person meeting certain criteria
- For routine physical examinations and rest cures

TERMINATION OF INSURANCE

INSURANCE ON AN INSURED WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The end of the last period for which premium has been paid
- The policy is terminated
- The insured retires
- The insured ceases to be on active service
- The insured's coverage in the underlying medical plan ends

INSURANCE ON A DEPENDENT WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The insured's insurance terminates
- The end of the last period for which premium has been paid
- The dependent no longer meets the definition of dependent
- The dependent's coverage in the underlying medical plan ends
- The policy is modified so as to exclude dependent insurance

THE COMPANY MAY END THE INSURANCE IF:

- Any insured person submits a fraudulent claim
- Participation requirements are not met
- On any premium due date, if the company or employer sends written notice 45 days in advance requesting termination
- If the underlying medical plan terminates

This is a brief summary of *TransConnect* ® Supplemental Medical Expense insurance, **underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa.** Policy form series CPGAP2FL and CCGAP2FL, rider form number TRLB1000-1119. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply.
Refer to the policy, certificate, and riders for complete details

Up-to-date information regarding our compensation practices can be found in the disclosures section of our website at tebcs.com

253889

Group Proposal For: TOWN OF PEMBROKE PARK
Quote Number: RI-101600

Proposal Expiration Date: 10/01/2023
Coverage Effective Date: 10/01/2023

Health Benefits and Rates Summary

2A 2B 2C 2D

Plan	BlueOptions All Copay 14001	BlueOptions All Copay 14002	BlueCare All Copay 14251	BlueCare All Copay 14252
Metal Level	**Platinum**	**Platinum**	**Platinum**	**Platinum**
Deductible (DED) (Per Person/Family Aggregate) In-Network Out-of-Network	 $250 / $750 $1,000 / $3,000	 $0 / $0 $500 / $1,000	 $250 / $750 NA / NA	 $0 / $0 NA / NA
Coinsurance (Plan Pays/Member Pays) In-Network Out-of-Network	 90% / 10% 50% / 50%	 100% / 0% 50% / 50%	 90% / 10% NA / NA	 100% / 0% NA / NA
Out of Pocket Maximum[2] (Per Person/Family Aggregate) In-Network Out-of-Network	 $2,450 / $4,900 $5,400 / $10,800	 $3,500 / $7,000 $7,000 / $14,000	 $2,450 / $4,900 NA / NA	 $3,500 / $7,000 NA / NA
Office Services – Value Choice PCP	$0 Copayment	$0 Copayment	$0 Copayment	$0 Copayment
Office Services - Family Physician	$10 Copayment	$15 Copayment	$10 Copayment	$15 Copayment
Office Services – Specialist	$25 Copayment	$30 Copayment	$25 Copayment	$30 Copayment
Virtual Visits – Family Physician	$0 Copayment	$0 Copayment	$0 Copayment	$0 Copayment
Inpatient Hospital Facility	Option 1: $250 Copayment per Day / $750 max / Option 2: $375 Copayment per Day / $1,125 max	Option 1: $300 Copayment per Day / $900 max / Option 2: $300 Copayment per Day / $900 max	$250 Copayment per Day / $750 max	$300 Copayment per Day / $900 max
Emergency Room Facility	$100 Copayment	$150 Copayment	$100 Copayment	$150 Copayment
Urgent Care Centers	$30 Copayment	$35 Copayment	$30 Copayment	$35 Copayment
Retail Pharmacy Deductible [3] Condition Care Rx [4] Generic/Brand Generic/Brand/Non-Preferred/Specialty Low Cost Generic/High Cost Generic & Brand/Non-Preferred & Specialty	 $0 $4 / $15 $10 / $30 / $50 / $150 NA	 $0 $4 / $15 $10 / $30 / $50 / $150 NA	 $0 $4 / $15 $10 / $30 / $50 / $150 NA	 $0 $4 / $15 $10 / $30 / $50 / $150 NA

Coverage Tier	# Members Quoted	Rates

2

Group Proposal For: TOWN OF PEMBROKE PARK
Quote Number: RI-101600

Proposal Expiration Date: 10/01/2023
Coverage Effective Date: 10/01/2023

2A 2B 2C 2D

Coverage Tier	# Members Quoted	Rates			
Employee Only	**29**	$989.07	$979.80	$863.24	$853.36
Employee/Spouse	**2**	$1,978.15	$1,959.60	$1,726.49	$1,706.72
Employee/Child(ren)	**8**	$1,829.79	$1,812.63	$1,597.00	$1,578.71
Employee Family	**8**	$2,818.86	$2,792.43	$2,460.24	$2,432.07
Total Monthly Premium	**47**	**$69,828.53**	**$69,173.88**	**$60,944.86**	**$60,247.12**

[1] **Florida Blue HSA Plans: Non- Embedded Deductible**- Deductible is shared for all individuals on plan. **Embedded Deductible** - Deductible must be met by each individual on the plan up to the family amount. **Embedded Out of Pocket** - Each individual on the plan will not pay more than the individual OOP amount.

[2] **The Out-of-Pocket Maximum is the most a member will pay for covered health care services during your plan's benefit period and includes Deductible, Coinsurance, and Copays.**

[3] **If a Deductible is present, it doesn't apply to Preventive or Condition Care Rx Generic and Brand prescription drugs. Review the Benefit Summary for the plan to determine if the deductible applies to any other prescription drugs.**

[4] **Condition Care Rx Lists are available in the Medication Guide.**

- **Preventive Medical Services and Preventive Prescription Drugs are covered at 100% in accordance with the Affordable Care Act.**
- **Certain services on BlueOptions and BlueSelect may be subject to an Exclusive Service Provider arrangement. Exclusive Provider Services: If the member does not receive care from an Exclusive Provider for pharmacy and/or benefit services, they will have to pay the full cost (except in certain situations, such as emergencies).**
- **The benefit summary is only a partial description of the many benefits and services provided or authorized by Florida Blue/Florida Blue HMO/FHCP.**
- **Benefit cost shares provided are only In-Network values unless otherwise specified.**

2

Town of Pembroke Park
BCBS Alternative Plans with GAP

The rates below for the GAP cover the out of pocket maximums for in and out of network.

2A

Status	BlueOptions Plan 14001 PPO/EPO	Transamerica GAP Plan	Total
Employee	$989.07	$94.33	$1,083.40
EE & Spouse	$1,978.15	$199.34	$2,177.49
EE & Child(ren)	$1,829.79	$168.69	$1,998.48
Family	$2,818.86	$297.25	$3,116.11

2B

Status	BlueOptions Plan 14002 PPO-EPO	Transamerica GAP Plan	Total
Employee	$979.80	$110.88	$1,090.68
EE & Spouse	$1,959.60	$232.96	$2,192.56
EE & Child(ren)	$1,812.63	$198.26	$2,010.89
Family	$2,792.43	$340.79	$3,133.22

The rates below for the GAP, only cover the out of pocket maximum for in network.

2C

Status	BlueCare Plan 14251 HMO	Transamerica GAP Plan	Total
Employee	$863.24	$41.42	$904.66
EE & Spouse	$1,726.49	$90.43	$1,816.92
EE & Child(ren)	$1,597.00	$72.07	$1,669.07
Family	$2,460.24	$128.97	$2,589.21

2D

Status	BlueCare Plan 14252 HMO	Transamerica GAP Plan	Total
Employee	$853.36	$52.92	$906.28
EE & Spouse	$1,706.72	$114.24	$1,820.96
EE & Child(ren)	$1,578.87	$92.45	$1,671.32
Family	$2,432.07	$167.73	$2,599.80

BlueOptions

For Small Groups
All Copay Health Plan 14001

Florida Blue
Your local Blue Cross Blue Shield

2A

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Financial Features		
Deductible (DED)[1] (PBP)[2] (DED is the amount the member is responsible for before Florida Blue pays)	$250 per person $750 per family	$1,000 per person $3,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	10% of the allowed amount	50% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$2,450 per person $4,900 per family	$5,400 per person $10,800 per family
Office Services		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$25 Copay	Not Covered
Physician Office Services		
Value Choice Primary Care Physician[4]	$0 Copay	DED + 50%
Value Choice Specialist[4]	$20 Copay	DED + 50%
Primary Care Physician	$10 Copay	DED + 50%
Specialist	$25 Copay	DED + 50%
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$10 Copay	DED + 50%
Specialist	$25 Copay	DED + 50%
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	DED + 50%
Specialist	$10 Copay	DED + 50%
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$25 Copay	DED + 50%
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) **Monthly Out-of-Pocket Maximum**[5]		
Low:	$100	NA
Standard:	$200	NA
Health Care Professional Administered Medications		
Low:	10%	DED + 50%
Standard:	20%	DED + 50%
Important Note: Physician-Administered Medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical benefit*. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		

[1]DED = Deductible / [2]PBP = Per Benefit Period / [3]Virtual Visit services are only covered for In-Network providers in Florida. / [4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / [5]In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

76772-0722R E (Platinum)

BlueOptions

For Small Groups
All Copay Health Plan 14001

Florida Blue
Your local Blue Cross Blue Shield

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0 Copay	50%
Mammograms	$0 Copay	$0 Copay
Colonoscopy (Routine for age 45+)	$0 Copay	$0 Copay
Emergency Medical Care		
Urgent Care Centers		
Value Choice Provider[4]	$0 Copay - Visits 1-2 PBP $30 Copay for Remaining Visits PBP	DED + $30
All Other Providers	$30 Copay	DED + $30
Emergency Room Facility Services[5] (per visit) (cost share waived if admitted)	$100 Copay	$100 Copay
Ambulance Services	DED + 10%	INN DED + 10%
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$50 Copay	DED + 50%
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$75 Copay	DED + 50%
Independent Clinical Lab (e.g., Blood Work)	$0 Copay	DED + 50%
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)		
Option 1	$200 Copay	DED + 50%
Option 2	$250 Copay	DED + 50%
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	DED + 50%
Outpatient Hospital Facility Services (per visit)		
Therapy Services Option 1	$35 Copay	DED + 50%
Option 2	$40 Copay	DED + 50%
All other Services Option 1	$200 Copay	DED + 50%
Option 2	$250 Copay	DED + 50%
Inpatient Hospital Facility and Rehabilitation Services[6] (per admit)		
Option 1	$250 per day ($750 Max)	DED + 50%
Option 2	$375 per day ($1125 Max)	DED + 50%

[4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / [6]If admitted as an Inpatient from the Emergency Room member pays the Option 1 In-Network Hospital cost share.

BlueOptions

For Small Groups
All Copay Health Plan 14001

Florida Blue
Your local Blue Cross Blue Shield

Mental Health / Substance Dependency		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Physician Office Services		
Primary Care Physician	$0 Copay	DED + 50%
Specialist	$0 Copay	DED + 50%
Emergency Room Facility Services[6] (per visit) (cost share waived if admitted)	$0 Copay	$0 Copay
Outpatient Hospitalization Facility Service (per visit)		
Option 1	$0 Copay	DED + 50%
Option 2	$0 Copay	DED + 50%
Inpatient Hospitalization Facility Services[6] (per admit)		
Option 1	$0 Copay	DED
Option 2	$0 Copay	DED
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$25 Copay	DED + 50%
Outpatient Hospital Facility Services (per visit) Option 1	$35 Copay	DED + 50%
Option 2	$40 Copay	DED + 50%
Durable Medical Equipment, Prosthetics and Orthotics	DED + 10%	DED + 50%
Home Health Care	DED + 10%	DED + 50%
Skilled Nursing Facility	DED + 10%	DED + 50%
Hospice	DED + 10%	DED + 50%

[3]Virtual Visit services are only covered for In-Network providers in Florida. / [6]If admitted as an Inpatient from the Emergency Room member pays the Option 1 In-Network Hospital cost share.

Important: There are certain medical services **for which members are required to obtain a prior authorization** on before receiving that service. If they don't, they will have to **pay the entire cost** of the service. Ensure they know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Summary of Benefits for Covered Services Amount Member Pays–Exclusive Pharmacy

Prescription Drug Program (BlueScript®)		
Exclusive Provider Services: An Exclusive Pharmacy must be used when a member needs to have a prescription filled or the member will have to pay the full cost of the drug (except in certain situations such as emergencies). Inform members to log into their member account at floridablue.com, click on **Find a Doctor** and follow the on-screen directions to locate an Exclusive Pharmacy.		
	Retail Pharmacy (1 month supply)	**Mail Order** (3 month supply)
Pharmacy Deductible	NA	
Generic Drugs:		
1. Preventive[7] (e.g., oral contraceptives)	$0	$0
2. Condition Care Rx[7] (high blood pressure, high cholesterol, diabetes, depression, and asthma)	$4	$8
3. All other Generics	$10	$20
Brand Drugs:		
4. Condition Care Rx[7] (high blood pressure, high cholesterol, diabetes, depression, and asthma)	$15	$30

5. All other Preferred Brand Drugs	$30	$60
Non-preferred Brand Drugs: 6. Non-preferred Brand Drugs	$50	$100
Specialty Drugs: 7. Specialty Drugs purchased from a Specialty Pharmacy	$150	Not Covered
Oral Chemotherapy Drugs *Specialty Drugs are not available through Mail Order	$10	$20

Important Notes

- Inform the member that if a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the member will be responsible for: 1) the Copayment applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueScript Pharmacy Program Schedule of Benefits.
- BlueScript Pharmacy benefit also provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost. Additionally, certain vaccines which are covered under the Wellness Benefits can be administered by Pharmacists who are certified.

[7]Preventive Medication and Condition Care Rx Lists are available in the Medication Guide.

Summary of Benefits for Covered Services	Amount Member Pays – Exclusive Provider
Pediatric Dental (under age 19)[8]	
Preventive, Basic and Major	$0
Pediatric Vision (under age 19)[8]	
Exclusive Provider Services: The services listed below must be received from an Exclusive Provider or the member will have to pay the full cost of the service (except in certain situations such as emergencies). Inform members to log onto floridablue.com, click on **Find a Doctor** and follow the on-screen directions to locate an Exclusive Provider near them.	
Exam	$0
Eyeglass Lenses	$0
Frames	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 20% discount (No discount at Sam's/Walmart)
Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 15% discount (No discount at Sam's/Walmart)
Note: Anything over the allowance will not go toward your out-of-pocket maximum.	

[8]Pediatric Dental and Vision Benefits end on the last day of the month of the member's 19th birthday.

Benefit Maximums	
Home Health Care	60 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Inpatient Habilitation Therapy	30 Days PBP
Outpatient Rehabilitation Therapy	35 Visits PBP
Outpatient Habilitation Therapy	35 Visits PBP
Spinal Manipulations	35 PBP(accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- Encourage our members to call the care consultants team at 1-888-476-2227 to find out more about their benefits and/or treatment options. This can help them save time and money.
- Let our members know that there is online access to about everything on their health benefit plan as well as all of our self-service tools.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueCare
For Small Groups
All Copay Health Plan 14252

Florida Blue HMO
Your local Blue Cross Blue Shield

2D

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Financial Features		
Deductible (DED)[1] (PBP)[2] (DED is the amount the member is responsible for before Florida Blue HMO pays)	$0 per person $0 per family	NA per person NA per family
Coinsurance (Coinsurance is the percentage the member pays for services)	0% of the allowed amount	NA
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$3,500 per person $7,000 per family	NA per person NA per family
Office Services		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$30 Copay	Not Covered
Physician Office Services		
Value Choice Primary Care Physician[4]	$0 Copay	Not Covered
Value Choice Specialist[4]	$20 Copay	Not Covered
Primary Care Physician	$15 Copay	Not Covered
Specialist	$30 Copay	Not Covered
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$15 Copay	Not Covered
Specialist	$30 Copay	Not Covered
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	Not Covered
Specialist	$10 Copay	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$30 Copay	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) **Monthly Out-of-Pocket Maximum**[5]		
Low:	$100	NA
Standard:	$200	NA
Health Care Professional Administered Medications		
Low:	10%	Not Covered
Standard:	20%	Not Covered
Important Note: Physician-Administered Medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical benefit*. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		

[1]DED = Deductible / [2]PBP = Per Benefit Period / [3]Virtual Visit services are only covered for In-Network providers in Florida. / [4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available. / [5]In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

BlueCare
For Small Groups
All Copay Health Plan 14252

Florida Blue
HMO
Your local Blue Cross Blue Shield

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0 Copay	Not Covered
Mammograms	$0 Copay	Not Covered
Colonoscopy (Routine for age 45+)	$0 Copay	Not Covered
Emergency Medical Care		
Urgent Care Centers		
Value Choice Provider[4]	$0 Copay - Visits 1-2 PBP $35 Copay for Remaining Visits PBP	Not Covered
All Other Providers	$35 Copay	Not Covered
Emergency Room Facility Services (per visit) (cost share waived if admitted)	$150 Copay	$150 Copay
Ambulance Services	DED	INN DED
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$75 Copay	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$150 Copay	Not Covered
Independent Clinical Lab (e.g., Blood Work)	$0 Copay	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	$250 Copay	Not Covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$200 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)		
Therapy Services	$40 Copay	Not Covered
All other Services	$250 Copay	Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	$300 per day ($900 Max)	Not Covered

[4]Value Choice Providers are only available in select counties. See the Agent Toolkit for a full list of counties where they are available.

Mental Health / Substance Dependency		
Virtual Visits[3]		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Physician Office Services		
Primary Care Physician	$0 Copay	Not Covered
Specialist	$0 Copay	Not Covered
Emergency Room Facility Services (per visit) (cost share waived if admitted)	$0 Copay	$0 Copay
Outpatient Hospitalization Facility Service (per visit)	$0 Copay	Not Covered
Inpatient Hospitalization Facility Services (per admit)	$0 Copay	Not Covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$30 Copay	Not Covered
Outpatient Hospital Facility Services (per visit)	$40 Copay	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics		
Motorized Wheelchair	DED	Not Covered
All Other	$0 Copay	Not Covered
Home Health Care	$0 Copay	Not Covered
Skilled Nursing Facility	DED	Not Covered
Hospice	DED	Not Covered

[3]Virtual Visit services are only covered for In-Network providers in Florida.

Summary of Benefits for Covered Services — Amount Member Pays

Prescription Drug Program (BlueCare Rx®)	**Preferred In-Network Retail Pharmacy** (1-month supply)	**Standard In-Network Retail Pharmacy** (1-month supply)	**In-Network Home Delivery** (3-month supply)	**Out-of-Network**
Pharmacy Deductible (PDED)		NA		Not Applicable
Generic Drugs:				
1. Preventive[6] (e.g., oral contraceptives)	$0	$10	$0	Not Covered
2. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$4	$14	$8	Not Covered
3. All Other Generics	$10	$20	$20	Not Covered
Brand Drugs:				
4. Condition Care Rx[6] (high blood pressure, high cholesterol, diabetes, depression and asthma)	$15	$35	$30	Not Covered
5. All Other Preferred Brand Drugs	$30	$40	$60	Not Covered
Non-Preferred Drugs:				
6. Non-Preferred Brand Drugs	$50	$70	$100	Not Covered
Specialty				
7. Specialty Drugs purchased from a Specialty Pharmacy	$150	$150	Not Covered	Not Covered
Oral Chemotherapy Drugs	$10	$10	$20	Not Covered

*Specialty Drugs are not available through Mail Order				

Important Notes

- Preferred Pharmacy Network includes Walgreens, Walmart, Publix, Winn-Dixie, and FHCP. To find a participating Preferred Pharmacy, please see our Online Provider Directory. Participating pharmacies will be identified with an orange "Preferred Pharmacy" designation.
- Home Delivery and Specialty Drugs are excluded from the Preferred Pharmacy Network.
- Inform the member that if a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the member will be responsible for: 1) the Copayment applicable to Brand Name Prescription Drugs; and 2) the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueCare Rx Pharmacy Program Schedule of Benefits.
- BlueCare Rx Pharmacy benefit also provides coverage for Generic contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) at no cost. Additionally, certain vaccines which are covered under the Wellness Benefits can be administered by Pharmacists who are certified.

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Pediatric Dental (under age 19)[7]		
Preventive, Basic and Major	$0	Not Covered
Pediatric Vision (under age 19)[7]		
Exam	$0	Not Covered
Eyeglass Lenses	$0	Not Covered
Frames	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 20% discount (No discount at Sam's/Walmart)	Not Covered
Contact Lenses *(Instead of eyeglasses)* Includes contact lenses, evaluation, fitting and follow up care.	Pediatric Selection: $0 Non-Selection: Amount over standard $150 allowance, minus a 15% discount (No discount at Sam's/Walmart)	Not Covered
Important Note: Anything over the allowance will not go toward your out-of-pocket maximum.		

[6]Preventive Medication and Condition Care Rx Lists are available in the Medication Guide. / [7]Pediatric Dental and Vision Benefits end on the last day of the month of the member's 19th birthday.

Benefit Maximums	
Home Health Care	60 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Inpatient Habilitation Therapy	30 Days PBP
Outpatient Rehabilitation Therapy	35 Visits PBP
Outpatient Habilitation Therapy	35 Visits PBP
Spinal Manipulations	35 PBP(accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Preauthorization for select services: Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Additional Benefits and Features

- Encourage our members to call the care consultants team at 1-888-476-2227 to find out more about their benefits and/or treatment options. This can help them save time and money.
- Let our members know that there is online access to about everything on their health benefit plan as well as all of our self-service tools.
- Let our members know they can go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in the plan's network and they don't need a referral to see a participating provider.

This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue HMO. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.