Bradford County Schools – effective 11/1/13

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** HSA Compatible 03160 (Single Coverage)	**BlueOptions** HSA Compatible 03161 (Family Coverage)	**BlueOptions** Predictable Cost 03359	**BlueOptions** HSA-Compatible 05182 (Single Coverage)	**BlueOptions** HSA-Compatible 05183 (Family Coverage)
Deductible (DED) (Per Person/Family Agg)					
In-Network	$1,250 / Not Applicable	$2,500 / $2,500	$1,000 / $3,000	$2,500 / Not Applicable	$5,000 / $5,000
Out-of-Network	$2,500 / Not Applicable	$5,000 / $5,000	$2,000 / $6,000	$5,000 / Not Applicable	$10,000 / $10,000
Coinsurance (Member Responsibility)					
In-Network	20%	20%	20%	10%	10%
Out-of-Network	40%	40%	40%	40%	40%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins, Copays	Includes DED, Coins, Copays	Includes DED, Coins, Copays (Excludes Rx)	Includes DED, Coins, & Copays	Includes DED, Coins, & Copays
In-Network	$5,000 / Not Applicable	$5,000 / $5,000	$3,000 / $6,000	$5,000 / Not Applicable	$10,000 / $10,000
Out-of-Network	$10,000 / Not Applicable	$10,000 / $10,000	$5,000 / $10,000	$10,000 / Not Applicable	$20,000 / $20,000
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES					
Allergy Injections					
In-Network Family Physician	DED + 20%	DED + 20%	$10	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Office Services					
In-Network Family Physician	DED + 20%	DED + 20%	$25	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Medical Pharmacy Monthly In-Network OOP Max (Provider-Administered Rx)*	$200 monthly member cap applies after DED	$200 monthly member cap applies after DED	$200 monthly member cap	$200 monthly member cap applies after DED	$200 monthly member cap applies after DED
In-Network	DED + 20%	DED + 20%	20% (No DED)	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%	DED + 50%	DED + 50%
Provider Services at Hospital and ER					
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Provider Services at Other Locations					
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center or Hospital					
In-Network Specialist	ASC: DED + 20% Hospital: DED + 20%	ASC: DED + 20% Hospital: DED + 20%	ASC: DED + 20% Hospital: DED + 20%	ASC: DED + 10% Hospital: DED + 10%	ASC: DED + 10% Hospital: DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
PREVENTIVE CARE					
Adult Wellness Office Services					
In-Network Family Physician	$0	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0	$0
Out-of-Network	40% (No DED)	40% (No DED)	40% (No DED)	40% (No DED)	40% (No DED)

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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	Age 50+ then Frequency Schedule Applies
In-Network	$0	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0	$0
Mammograms (Routine and Dx)					
In-Network	$0	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0	$0
Well Child Office Visits (No BPM)					
In-Network Family Physician	$0	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0	$0
Out-of-Network	40% (No DED)	40% (No DED)	40% (No DED)	40% (No DED)	40% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE					
Ambulance Maximum (combined ground, air and water - per day)	$5,500	$5,500	$5,500	$5,500	$5,500
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Convenient Care Centers (CCC)					
In-Network	DED + 20%	DED + 20%	$25	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)					
In-Network	DED + 20%	DED + 20%	$200	DED + 10%	DED + 10%
Out-of-Network	DED + 20%	DED + 20%	$200	DED + 10%	DED + 10%
Urgent Care Centers (UCC)					
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	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.					
Ambulatory Surgical Center					
In-Network	DED + 20%	DED + 20%	$100	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Independent Clinical Lab					
In-Network	DED	DED	$0	DED	DED
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)					
In-Network - Advanced Imaging Services (AIS)	DED + 20%	DED + 20%	$125	DED + 10%	DED + 10%
In-Network - Other Diagnostic Services	DED + 20%	DED + 20%	$50	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Inpatient Hospital (per admit)					
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%	DED + 20%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Inpatient Rehab Maximum	21 Days	21 Days	21 Days	21 Days	21 Days

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Outpatient Hospital (per visit)					
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%	DED + 20% DED + 20%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Therapy at Outpatient Hospital					
In-Network	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - DED + 20% Option 2 - DED + 25%	Option 1 - $45 Option 2 - $60	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE					
Inpatient Hospitalization					
In-Network	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Outpatient Hospitalization (per visit)					
In-Network	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 20% Option 2 - DED + 20%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Provider Services at Hospital and ER					
In-Network Family Physician or Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network Provider	In-Ntwk DED + 20%	In-Ntwk DED + 20%	DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Physician Office Visit					
In-Network Family Physician or Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Emergency Room Facility Services (per visit)					
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%	DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Provider Services at Locations other than Hospital and ER					
In-Network Family Physician and Specialist	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
OTHER SPECIAL SERVICES AND LOCATIONS					
Advanced Imaging Services in Physician's Office					
In-Network Family Physician	DED + 20%	DED + 20%	$125	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	$125	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Birthing Center					
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM					
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Home Health Care BPM	20 Visits	20 Visits	20 Visits	20 Visits	20 Visits
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%

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Hospice LTM	No Maximum	No Maximum	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM	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)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days	60 Days	60 days	60 Days	60 Days
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%	DED + 40%	DED + 40%
PRESCRIPTION DRUGS					
Deductible	Calendar Year Deductible (CYD)	Calendar Year Deductible (CYD)	$100 Retail/Mail Order combined RX deductible	Calendar Year Deductible (CYD)	Calendar Year Deductible (CYD)
In-Network					
Retail (30 days)	CYD then	CYD then	$100 then	CYD then	CYD then
Generic/Preferred Brand/Non-Preferred	$10/$50/$80	$10/$50/$80	$15/$50/$70	$10/$50/$80	$10/$50/$80
Mail Order (90 days)					
Generic/Preferred Brand/Non-Preferred	$25/$125/$200	$25/$125/$200	$40/$125/$175	$25/$125/$200	$25/$125/$200
Out-of-Network					
Retail (30 days)					
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Mail Order (90 days)					
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Specialty Drugs/Pharmacy – CareMark 1-866-278-5108 (30 days)					
In Network - CareMark	CYD then applicable copay	CYD then applicable copay	$100 then applicable copay	CYD then applicable copay	CYD then applicable copay
Out of Network	CYD then 50%	CYD then 50%	$100 then 50%	CYD then 50%	CYD then 50%
PREMIUMS					
Employee / Family 24 pay	$ 50.00	$ 215.00	$ 221.86 / $694.90	$ 30.00	$ 160.00
Employee / Family 20 pay	$ 60.00	$ 258.00	$ 266.23 / $833.88	$ 36.00	$ 192.00

* (1) Medical Pharmacy Monthly 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 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.

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. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary. Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE).