Holmes County School District

October 1, 2010 - BLUE OPTIONS PLAN 3769

BCBSF is currently reviewing all health care reform legislation—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act—which includes numerous provisions to expand access to health insurance, improve the quality and comprehensiveness of coverage, and make coverage more affordable for all Americans. Although some major elements of reform begin in 2010, others will be implemented over the next several years. Therefore, the information in our enrollment materials is subject to change based on the final result of this legislation.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	**BlueOptions** Predictable Cost 3769
Deductible (DED) (Per Person/Family Agg)	
In-Network	$500 / $1,500
Out-of-Network	$1,500 / $4,500
Coinsurance (Member Responsibility)	
In-Network	20%
Out-of-Network	50%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins, Copays; Excludes Rx
In-Network	$3,000 / $6,000
Out-of-Network	$6,000 / $12,000
Lifetime Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES	
Allergy Injections	
In-Network Family Physician	$10
In-Network Specialist	$10
Out-of-Network	DED + 50%
E-Office Visit Services	
In-Network Family Physician	$10
In-Network Specialist	$10
Out-of-Network	DED + 50%
Office Services	
In-Network Family Physician	$25 FP
In-Network Specialist	$60 SP
Out-of-Network	DED + 50%
Provider Services at Hospital and ER	
In-Network Family Physician	$100
In-Network Specialist	$100
Out-of-Network	$100
Provider Services at Other Locations	
In-Network Family Physician	$25 FP
In-Network Specialist	$60 SP
Out-of-Network	DED + 50%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center	
In-Network Specialist	$60 SP
Out-of-Network	In-Ntwk $60 SP
PREVENTIVE CARE	
Adult Wellness Office Services	
In-Network Family Physician	$25 FP
In-Network Specialist	$60 SP
Out-of-Network	50% (No DED)
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies
In-Network	$0
Out-of-Network	$0
Mammograms (Routine and Dx)	
In-Network	$0
Out-of-Network	$0
Well Child Office Visits (No BPM)	
In-Network Family Physician	$25 FP
In-Network Specialist	$60 SP
Out-of-Network	50% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE	
Ambulance Maximum (per Day)	$5,000
In-Network	DED + 20%
Out-of-Network	In-Ntwk DED + 20%
Convenient Care Centers (CCC)	
In-Network	$25 FP
Out-of-Network	DED + 50%

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Emergency Room Facility Services (also see Professional Provider Services) In-Network Out-of-Network	 $300 DED + 50%
Urgent Care Centers (UCC) In-Network Out-of-Network	 $65 DED + 50%
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 Out-of-Network	 DED + 20% DED + 50%
Independent Clinical Lab In-Network Out-of-Network	 $0 DED + 50%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) In-Network - Other Diagnostic Services Out-of-Network	 DED + 20% $50 DED + 50%
Inpatient Hospital (per admit) In-Network Out of State- In Network Out-of-Network	 Option 1 - DED + 20% Option 2 - DED + 20% Option 1 – DED + 20% $3,000
Inpatient Rehab Maximum	21 Days
Outpatient Hospital (per visit) In-Network Out of State In Network Out-of-Network	 Option 1 - DED + 20% Option 2 - DED + 20% Option 1 – DED & 20% DED + 50%
Therapy at Outpatient Hospital In-Network Out-of-Network	 Option 1 - $45 Option 2 - $60 DED + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Hospitalization In-Network Out-of-Network	 Option 1 - $0 Option 2 - $0 50% (No DED)
Outpatient Hospitalization (per visit) In-Network Out-of-Network	 Option 1 - $0 Option 2 - $0 50% (No DED)
Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider	 $0 $0
Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider	 $0 50% (No DED)
Emergency Room Facility Services (per visit) In-Network Out-of-Network	 $0 $0
Provider Services at Locations other than Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network Provider	 $0 $0 50% (No DED)
OTHER SPECIAL SERVICES AND LOCATIONS	
Advanced Imaging Services in Physician's Office In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% DED + 20% DED + 50%
Birthing Center In-Network Out-of-Network	 DED + 20% DED + 50%
Diabetic Equipment and Supplies* In-Network Out-of-Network	 DED + 20% DED + 50%
Durable Medical Equipment, Prosthetics, Orthotics BPM	Enteral Formulas:$2,500 All Other: No Maximum

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In-Network	DED + 20%
Out-of-Network	DED + 50%
Home Health Care BPM	20 Visits
In-Network	DED + 20%
Out-of-Network	DED + 50%
Hospice LTM	No Maximum
In-Network	DED + 20%
Out-of-Network	DED + 50%
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days
In-Network	DED + 20%
Out-of-Network	DED + 50%
PRESCRIPTION DRUGS	
In-Network (30 day supply) Generic/Preferred Brand/Non-Preferred	$15/$30/$50
Mail Order (90 Days supply) Generic/Preferred Brand/Non-Preferred	$40/$75/$125
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.