

# Benefit Comparison

Alachua County Public Schools  
January 1, 2008



	<b>New Plan I</b> \$500 Deductible	<b>Plan II</b> \$500 Deductible (same as current Opt. 1)	<b>New Plan III</b> Physician Copay \$300	<b>New Plan IV</b> Physician Copay \$750	<b>New Plan V</b> Physician Copay \$1,500
<b>Product Network</b>	<b>BlueOptions Network Blue</b>	<b>BlueChoice Current (PPC)</b>	<b>BlueOptions Network Blue</b>	<b>BlueOptions Network Blue</b>	<b>BlueOptions Network Blue</b>
<b>CALENDAR YEAR DEDUCTIBLE (CYD)</b>					
Individual/ Family Aggregate	\$500 (3 x per family)	\$500 (3 x per family)	\$300 (3 x per family)	\$750 (3 x per family)	\$1,500 (3 x per family)
4 <sup>th</sup> Quarter Deductible Carryover	Does not apply	Applies	Does not Apply	Does not apply	Does not apply
<b>COINSURANCE: All Coinsurance is Expressed as the Percentage YOU PAY</b>					
In-Network/Out-of-Network	20% / 40%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
<b>PRESCRIPTION DRUGS</b>					
Retail 30 Day Supply	<b>BlueScript:</b> \$50 Rx-only deductible, then you pay 20% generic / 40% brand at pharmacy; no filing.	<b>Mediscript:</b> Subject to Calendar Year Deductible, then your responsibility is 20%. Member pays discounted price in full and files for reimbursement.	<b>BlueScript:</b> \$50 Rx-only deductible, then you pay 20% generic / 40% brand at pharmacy; no filing.	<b>BlueScript:</b> \$50 Rx-only deductible, then you pay 20% generic / 40% brand at pharmacy; no filing.	<b>BlueScript:</b> \$50 Rx-only deductible, then you pay 20% generic / 40% brand at pharmacy; no filing.
Mail Order 90Day Supply	\$20 Generic / \$50 preferred brand / \$80 non-preferred brand	\$20 Generic / \$50 Brand	\$20 Generic / \$50 preferred brand* / \$80 non-preferred brand	\$20 Generic / \$50 preferred brand* / \$80 non-preferred brand	\$20 Gen. / \$50 preferred brand* / \$80 non-preferred brand
<b>DIABETIC MEDICATIONS AND SUPPLIES</b>					
	Insulin, Needles, Syringes and all diabetic supplies (e.g. test strips, lancets) – covered under pharmacy benefit. Insulin pump and related supplies are subject to Calendar Year Deductible and Coinsurance. Glucose monitor available at no cost at pharmacy.	Insulin, Needles & Syringes covered under pharmacy benefit. Other Supplies (e.g. test strips, lancets) subject to Calendar Year Deductible and Coinsurance either under pharmacy or other medical supplier. Glucose monitor available at no cost through Byram Healthcare	Insulin, Needles, Syringes and all diabetic supplies (e.g. test strips, lancets) – covered under pharmacy benefit. Insulin pump and related supplies are subject to the Calendar Year Deductible and Coinsurance. Glucose monitor available at no cost at pharmacy.	Insulin, Needles, Syringes and all diabetic supplies (e.g. test strips, lancets) – covered under pharmacy benefit. Insulin pump and related supplies are subject to the Calendar Year Deductible and Coinsurance. Glucose monitor available at no cost at pharmacy.	Insulin, Needles, Syringes and all diabetic supplies (e.g. test strips, lancets) – covered under pharmacy benefit. Insulin pump and related supplies are subject to the Calendar Year Deductible and Coinsurance. Glucose monitor available at no cost at pharmacy.

This does not constitute a contract and is only a summary of benefits. For a complete description of benefits and exclusions, please see your Master Policy; its terms prevail.

Preferred Medication List is on our website [www.bcbsfl.com](http://www.bcbsfl.com) and will be mailed to you with your ID card.

	<b>New Plan I</b> A BlueOptions Plan \$500 Deductible	<b>Plan II</b> A BlueChoice Plan \$500 Deductible	<b>New Plan III</b> A BlueOptions Plan Physician Copay \$300	<b>New Plan IV</b> A BlueOptions Plan Physician Copay \$750	<b>New Plan V</b> A BlueOptions Plan Physician Copay \$1,500
<b>PHYSICIAN'S SERVICES - All Coinsurance is Expressed as the Percentage YOU PAY. In/Out of Network</b>					
In Physician's Office	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	In Network Family Physician* - \$20 copay, then covered 100%. All other Physicians – Calendar Year Deductible, then 20/40 Coinsurance. Allergy Injections at in-network Family Physician's office - \$10 copay then covered at 100%	In Network Family Physician* - \$20 copay, then covered 100%. All other Physicians – Calendar Year Deductible, then 20/40 Coinsurance. Allergy Injections at in-network Family Physician's office - \$10 copay then covered at 100%	In Network Family Physician* - \$25 copay, then covered 100%. All other Physicians – Calendar Year Deductible, then 20/40 Coinsurance. Allergy Injections at in-network Family Physician's office - \$10 copay then covered at 100%
At Hospital: Inpatient, Outpatient, or ER	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.
At Ambulatory Surgical Center Facility	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.
<b>HOSPITAL SERVICES - All Coinsurance is Expressed as the Percentage YOU PAY</b>					
Inpatient In-Network (Co-pays are per admission)	Option 1 Hosp: \$600 Copay Option 2 Hosp: \$900 Copay	Calendar Year Deductible, then 20% Coinsurance.	Option 1 Hosp: \$500 Copay Option 2 Hosp: \$750 Copay	Option 1 Hosp: \$750 Copay Option 2 Hosp: \$1000 Copay	Calendar Year Deductible, then 20% Coinsurance.
Inpatient Out-of-Network	Calendar Year Deductible, then 40% Coinsurance	Calendar Year Deductible, then 40% Coinsurance	Calendar Year Deductible, then 40% Coinsurance	Calendar Year Deductible, then 40% Coinsurance	Calendar Year Deductible, then 40% Coinsurance
Outpatient In-Network (Co-pays are per visit)	Option 1 Hosp: \$150 Copay Option 2 Hosp: \$250 Copay	Calendar Year Deductible, then 20% Coinsurance.	Option 1 Hosp: \$100 Copay Option 2 Hosp: \$200 Copay	Option 1 Hosp: \$150 Copay Option 2 Hosp: \$250 Copay	Calendar Year Deductible, then 20% Coinsurance.
Outpatient Out-of-Network	Calendar Year Deductible, then 40% Coinsurance.	Calendar Year Deductible, then 40% Coinsurance.	Calendar Year Deductible, then 40% Coinsurance.	Calendar Year Deductible, then 40% Coinsurance.	Calendar Year Deductible, then 40% Coinsurance.
Emergency Room In-Network	\$100 Copay (Per visit; waived if admitted)	Calendar Year Deductible, then 20% Coinsurance. (CYD waived for accidents)	\$100 Copay (Per visit; waived if admitted)	\$100 Copay (Per visit; waived if admitted)	Calendar Year Deductible, then 20% Coinsurance.
Emergency Room Out-of-Network	\$200 Copay (Per visit; waived if admitted)	Calendar Year Deductible, then 40% Coinsurance. (CYD waived for accidents)	\$200 Copay (Per visit; waived if admitted)	\$200 Copay (Per visit; waived if admitted)	Calendar Year Deductible, then 40% Coinsurance.

\* Family Physicians are Family Practitioners, General Practitioners, Internal Medicine and Pediatricians.

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<b>OUT-OF-POCKET MAXIMUM</b>					
Individual Family Aggregate	\$3000 Per Calendar Year. (x 2 per family) (Includes CY Deductible, Facility Copays, and Coinsurance for Medical services, but does not include Rx. Does not include balance billing from out-of-network providers)	\$2500 Per Person per CY. (No Family Aggregate) (Includes all Coinsurance for Medical and Rx, but does not include CY Deductible. Does not include balance billing from out-of-network providers)	\$3000 Per Calendar Year. (x 2 per family) (Includes CY Deductible, Facility Copays, Office Visit Copays, and Coinsurance for Medical services, but does not include Rx. Does not include balance billing from out-of-network providers)	\$4000 Per Calendar Year. (x 2 per family) (Includes CY Deductible, Facility Copays, Office Visit Copays, and Coinsurance for Medical services, but does not include Rx. Does not include balance billing from out-of-network providers)	\$4000 Per Calendar Year. (x 2 per family) (Includes CY Deductible, Office Visit Copays, and Coinsurance for Medical services, but does not include Rx. Does not include balance billing from out-of-network providers)
<b>OTHER – All Coinsurance is Expressed as the Percentage YOU PAY</b>					
Ambulatory Surgical Center	\$100 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	Calendar Year Deductible, then 20/40 Coinsurance.	\$75 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	\$100 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	Calendar Year Deductible, then 20% In-Network, 40% Out-of-Network
Independent Clinical Labs	\$0 In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	Calendar Year Deductible, then 20/40 Coinsurance.	\$0 In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	\$0 In-Network; CY Deductible, then 40% Coinsurance Out-of- Network	\$0 In-Network; CY Deductible, then 40% Coinsurance Out-of- Network
Independent Diagnostic Testing Facility	\$100 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	Calendar Year Deductible, then 20/40 Coinsurance.	\$100 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	\$100 Copay per visit In-Network; CY Deductible, then 40% Coinsurance Out-of-Network	\$100 Copay per visit In- Network; CY Deductible, then 40% Coinsurance Out-of-Network
Prosthetics & Orthotics	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.
Durable Medical Equipment	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.	Calendar Year Deductible, then 20/40 Coinsurance.
Ambulance Services	CY Deductible, then 20%. Benefit Max is \$400 Per Day Ground & \$4000 Per Day Air/Water	CY Deductible, then 20% Coinsurance (CY Ded. waived for accidents)	CY Deductible, then 20%. Benefit Max is \$400 Per Day Ground & \$4000 Per Day Air/Water	CY Deductible, then 20%. Benefit Max is \$400 Per Day Ground & \$4000 Per Day Air/Water	CY Ded., then 20%. Benefit Max is \$400 Per Day Ground & \$4000 Per Day Air/Water
Self-Injectibles	Medication Guide has list of self- injectible covered under pharmacy benefit. Some require prior authorization. Pharmacy benefit will apply at either the pharmacy or the injectible Drug Provider. Physician administered injectibles covered under medical	Covered under medical benefit; subject to deductible and coinsurance from injectible suppliers. Only insulin, imitrix and epi-pen covered under pharmacy benefit.	Medication Guide has list of self-injectible covered under pharmacy benefit. Some require prior authorization. Pharmacy benefit will apply at either the pharmacy or the injectible Drug Provider. Physician administered injectibles covered under medical.	Medication Guide has list of self- injectible covered under pharmacy benefit. Some require prior authorization. Pharmacy benefit will apply at either the pharmacy or the injectible Drug Provider. Physician administered injectibles covered under medical	Medication Guide has list of self- injectible covered under pharmacy benefit. Some require prior authorization. Pharmacy benefit will apply at either the pharmacy or the injectible Drug Provider. Physician administered injectibles cov under medical

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<b>PREVENTIVE HEALTH – All Coinsurance is Expressed as the Percentage YOU PAY</b>					
Mammograms (Routine & Diagnostic)	Covered 100% of Allowed Amount	Covered 100% of Allowed Amount	Covered 100% of Allowed Amount	Covered 100% of Allowed Amount	Covered 100% of Allowed Amount
Well Child	No CY Deductible, 20/40 Coinsurance Only	No CY Deductible, 20/40 Coinsurance Only	No CY Ded. at any location. \$20 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations	No CY Deductible at any location. \$20 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations	No CY Deductible at any location. \$25 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations
Adult Wellness	No CY Deductible, 20/40 Coinsurance Only  Max benefit per Cal. Year is \$250	No CY Deductible, 20/40 Coinsurance only.  Max Benefit per Cal. year is \$150	No CY Ded. at any location. \$20 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations  Max Benefit per Cal. year is \$250	No CY Deductible at any location. \$20 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations  Max Benefit per Cal. year is \$150	No CY Deductible at any location. \$25 Copay, then covered at 100% at in-network Family Physician's* Office. 20/40 Coinsurance applies at all other locations  Max Benefit per Cal. year is \$150
<b>BENEFIT MAXIMUMS</b>					
Lifetime Maximum	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Substance Dependency	\$2,500 Lifetime Maximum	\$2,000 Lifetime Maximum	\$2,500 Lifetime Maximum	\$2,500 Lifetime Maximum	\$2,500 Lifetime Maximum
Mental & Nervous Disorders	30 Days Inpatient / 20 Days Outpatient per Calendar Year	30 Days Inpatient / 20 Days Outpatient per Calendar Year	30 Days Inpatient / 20 Days Outpatient per Calendar Year	30 Days Inpatient / 20 Days Outpatient per Calendar Year	30 Days Inpatient / 20 Days Outpatient per Calendar Year
Hospice	\$7,500 Lifetime Maximum	\$5,200 Lifetime Maximum	\$7,500 Lifetime Maximum	\$7,500 Lifetime Maximum	\$7,500 Lifetime Maximum
Home Health Care	\$2,500 Calendar Year Maximum	\$2,000 Calendar Year Maximum	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Max
Skilled Nursing Facility	60 Days Calendar Year Maximum	60 Days Calendar Year Maximum	60 Days Calendar Year Maximum	60 Days Calendar Year Maximum	60 Days Calendar Year Maximum
OP Therapy and Spinal Manipulations	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Maximum	\$2,500 Calendar Year Maximum

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